91-634

No. _____

In The

Supreme Court of the United States

October Term, 1991

INDEPENDENT NURSING HOME ASSOCIATION and MISSISSIPPI HEALTH CARE ASSOCIATION,

Petitioners,

vs.

J. CLINTON SMITH, M.D., IN HIS OFFICIAL CAPACITY AS DIRECTOR OF THE STATE OF MISSISSIPPI DIVISION OF MEDICAID IN THE OFFICE OF THE GOVERNOR, and THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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October 14, 1991

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QUESTIONS PRESENTED

Under what circumstances will significant proposed changes to a state's Medicaid reimbursement plan be excepted from public notice under 42 C.F.R. § 447.205(b)(1)? More specifically, was the Fifth Circuit Court of Appeals correct in holding that Mississippi's Division of Medicaid was not required to provide public notice in adopting Plan Amendment No. 84-36?

PARTIES TO THE PROCEEDING BELOW

The parties in the court below were:

Plaintiffs: Independent Nursing Home Association and Mississippi Health Care Association.

Defendants: J. Clinton Smith, M.D., in His Official Capacity as Director of the State of Mississippi Division of Medicaid in the Office of the Governor. J. Clinton Smith is the successor to B. F. Simmons, who previously held said position and who was the original Defendant in this lawsuit.

The Secretary of the United States Department of Health and Human Services was named as a necessary party Defendant by the United States District Court for the Southern District of Mississippi.

This Petition for Writ of Certiorari is being filed on behalf of the Mississippi Health Care Association only.

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No. _____

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Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

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INTRODUCTION

The Petitioner, Mississippi Health Care Association, respectfully prays that a writ of certiorari issue to review the judgment and opinion the United States Court of Appeals for the Fifth Circuit entered in the above-entitled proceeding on July 16, 1991.

OPINIONS BELOW

The July 16, 1991 opinion of the Court of Appeals for the Fifth Circuit is reported at 936 F.2d 793, and is reprinted in the Appendix hereto at 1a. The July 16, 1991 opinion replaced an earlier opinion of the Fifth Circuit which was rendered on April 11, 1991, and which was reported at 928 F.2d 181. That opinion is also reprinted in the Appendix hereto at 10a.

The Memorandum Opinion and Order of the United States District Court for the Southern District of Mississippi was reported at 732 F. Supp. 684. It is reprinted in the Appendix hereto at 20a.

JURISDICTION

Invoking federal jurisdiction under 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331 and 1343, the Petitioner brought this suit in the United States District Court for the Southern District of Mississippi. On March 2, 1990, the district court granted the Petitioner's motion for summary judgment and denied the Defendants' cross-motions for dismissal or, in the alternative, for summary judgment. A Final Judgment was entered by the district court on March 12, 1990, granting summary judgment to the Petitioner as well as other injunctive relief.

On Respondent State Division of Medicaid's appeal, the United States Court of Appeals for the Fifth Circuit entered an opinion reversing the district court's ruling on April 11, 1991. A petition for rehearing was filed by the Mississippi Health Care Association on April 25, 1991. On

July 16, 1991, the MHCA's petition for rehearing was granted, and the Fifth Circuit replaced its earlier opinion with a new opinion, still reversing the district court's ruling. Judgment was also entered by the Fifth Circuit on July 16, 1991.

The jurisdiction of this Court to review the judgment of the Fifth Circuit is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395x(v) (1) (O) (Supp. 1991), as amended
This statute is reprinted in App. D, p. 35a.

42 C.F.R. § 447.205
This regulation is reprinted in App. E, p. 37a.

42 C.F.R. § 447.253, as amended
This regulation is reprinted in App. F, p. 39a.

STATEMENT OF THE CASE

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (1974), provides for the establishment of cooperative federal-state Medicaid programs for the purpose of enabling states to furnish medical assistance to certain low-income individuals. The Mississippi Medicaid Law, Miss. Code Ann. §§ 43-13-101 *et seq.* (as amended), establishes a statewide Medicaid system by which Mississippi participates in the federally assisted Medicaid program under a state Long-Term Care Reimbursement Plan. The State Division of Medicaid (hereinafter "DOM") is the

Mississippi agency responsible for implementing the State's Medicaid program. DOM receives federal subsidies for its Medicaid program provided that its Long-Term Care Reimbursement Plan complies with the applicable federal requirements. The Health Care Financing Administration Division of the Department of Health and Human Services (hereinafter "HCFA") is the federal agency which oversees all state Medicaid plans, and its approval is a prerequisite for federal financial assistance.

Before a state plan can be approved by HCFA, the state is required to show that it has complied with several federal regulations. One such regulation, and the one most relevant to this action, is found at 42 C.F.R. § 447.205, which provides that "[e]xcept as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services." Subsection (b) of the regulation provides that notice is not required if "[t]he change is being made to conform to Medicare methods or levels of reimbursement." (Section 447.205 is set forth in its entirety at Appendix E, p. 37a). Likewise, 42 C.F.R. § 447.253, as amended, provides that to receive HCFA approval of a change in payment methods and standards, a state agency must make assurances satisfactory to HCFA that certain requirements have been met and that it has complied with all pertinent regulations. Subpart (f) of § 447.253 provides that "[t]he Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting

payment rates for inpatient hospital or LTC facility services." (Section 447.253, as amended, is set forth in its entirety at Appendix F, p. 39a).

In mid-1984, Congress passed the Deficit Reduction Act (hereinafter "DEFRA") which, among other things, modified federal financial assistance requirements for both Medicare and Medicaid. Most relevant to this action, DEFRA limited the amount of Medicare and Medicaid payments that states can pay upon the sale or transfer of a nursing home facility. Section 2314 of DEFRA amended 42 U.S.C. § 1396a(a) (13) (B) to limit the change in Medicaid reimbursement rates for property costs due to a change of ownership to the amount of change which would have been allowed under Medicare.

DEFRA's amendment to the Medicare reimbursement scheme, the limits of which would also apply to Medicaid under the terms of DEFRA, is found at 42 U.S.C. § 1395x(v) (1) (O). (See entire statute, as amended, set forth at Appendix D, p. 35a).[1] The amendment to Medicare provided that a long-term care facility undergoing a change of ownership must be re-evaluated at a cost no higher than the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (the date of enactment), or the acquisition cost of such asset to the new owner (the purchase price). The amendment also

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[1] The text of § 1395x(v) (1) (O) found at Appendix D is that found in the 1991 Supplement. The only change in the statute since the date of enactment is the inclusion of subpart (iv), which has no relevance to this action.

provided for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984. Appendix D, p. 35a. The effect of DEFRA on re-evaluation of assets and recapture of depreciation, is most relevant to this litigation.[2] Re-evaluation of assets invoives the calculation of the Medicaid reimbursement rate to the new owner of a long-term care facility while recapture of depreciation involves the recoupment of Medicaid-paid depreciation from the former owner.

At the time DEFRA was enacted, Mississippi's Medicaid plan was governed by Transmittal No. 84-9. (For pertinent provisions of Transmittal No. 84-9, see Appendix G, p. 42a). Soon thereafter, DOM drafted a plan amendment known as Transmittal No. 84-36. (For pertinent provisions of Transmittal No. 84-36, see Appendix H, p. 52a). Transmittal No. 84-36 made significant changes in Mississippi's plan with regard to re-evaluation of assets and recapture of depreciation. Under Transmittal No. 84-9, the value of a long-term care facility to a new owner was generally the lesser of its purchase price, the fair market value, or the sum of its historical depreciable basis prior to the sale and a variable portion of the difference between that basis and the home's fair market value. Under Transmittal No. 84-36, the new valuation was limited to the lesser of the purchase price and the acquisition costs borne by the owner of record as of July 18, 1984. However, as the Fifth Circuit noted, 84-36, unlike the Medicare provisions, "included a few extra

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[2] The Complaints originally challenged other aspects of the State plan, but those issues were settled by the parties out of court.

provisions that DOM believed would further restrain any upward re-evaluation in nursing home value, such as a provision that, for purposes of determining a new owner's interest expense, precluded a new owner from treating as indebtedness any amount greater than the indebtedness that saddled the old owner as of the sale date." Appendix A, p. 5a.

With regard to recapture of depreciation, Transmittal No. 84-36 completely eliminated a forgiveness provision which was contained in Transmittal No. 84-9. Transmittal 84-9 provided for payment to facility owners of reimbursement for depreciation of a depreciable asset. Under 84-9, if the facility was sold within four (4) years, all of the amounts paid for depreciation could be recaptured. However, if a facility was owned beyond 4 years, the plan provided for a reduction on a monthly basis in the amount of depreciation reimbursements which could be recaptured upon a change in ownership. This plan gradually phased out any recapture of depreciation once an owner had owned a facility for a period of nine (9) years, after which time all reimbursements for depreciation would be forgiven. Transmittal 84-36 completely eliminated this phase-out provision. No party to this action denies that the changes embodied in Transmittal No. 84-36 were significant within the meaning of 42 C.F.R. § 447.205.

Once the State had drafted and submitted Transmittal No. 84-36 to HCFA, HCFA notified DOM on December 27, 1984, that "[t]he State has not submitted the assurances and related information required for significant plan amendments as specified at 42 C.F.R. § 447.253." Appendix I, p. 65a. The letter also stated, "However, due

to the fact that the amendment could apply to all providers and the extensive provider interest in this matter, the plan amendment should be considered significant and the appropriate assurances specified at 42 C.F.R. § 447.253 should be submitted." Appendix I, p. 65a. On February 26, 1985, DOM presented HCFA with additional information regarding Transmittal 84-36. Although said correspondence from the State to HCFA stated that "[p]ublic notice is not required as the change is to bring the State in compliance as a result of statutory change," the correspondence later also confusingly stated that "[a] copy of the public notice is enclosed." Appendix J, pp. 67a, 68a. No public notice was ever forwarded to HCFA, because no public notice was ever provided for Transmittal No. 84-36.

In considering Transmittal No. 84-36, HCFA found that "[s]ince these provisions are, in effect, more restrictive than Medicare rules with regard to revaluation of assets, we recommend acceptance of the State's assurance." Appendix K, p. 73a. Plan Amendment 84-36 was approved by HCFA on May 1, 1985, with an effective date of October 1, 1984.[3] Since no public notice of 84-36 was ever given, many owners of long-term health care facilities who sold their facilities after 84-36's effective date accrued substantial recapture

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[3] In 1987, DOM submitted another Transmittal, No. 87-8, which was identical to 84-36, but 87-8 was accompanied by public notice. Transmittal 87-8 was approved by HCFA on July 7, 1987, with an effective date of April 1, 1987. Therefore, DOM contends that 84-36 controls as to transactions taking place between October 1, 1984, and April 1, 1987. The validity of Transmittal 87-8 has been challenged successfully in state court for violation of state law not relevant to this action.

liability under the amended plan. Many of those owners would not have accrued such liability under Transmittal No. 84-9's recapture phase-out provisions.

Once the existence of Transmittal No. 84-36 was discovered, two lawsuits were filed independently by the Mississippi Health Care Association (hereinafter "MHCA") and the Independent Nursing Home Association, both nonprofit Mississippi corporations charted for the purpose of advancing the interests of member long-term health care facilities licensed to operate in the state of Mississippi. MHCA is comprised of approximately one hundred two (102) member facilities, while INHA has approximately thirty-one (31) member facilities. The separate lawsuits were filed in federal court, invoking jurisdiction under 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331 and 1343. The associations sought declaratory, injunctive and other relief which would preclude enforcement of Transmittal No. 84-36 for failure to provide public notice under 42 C.F.R. § 447.205. The two causes of action were consolidated on January 30, 1987.

Once litigation regarding the failure to provide public notice was commenced, HCFA, in response to inquiries by DOM, informed DOM as follows:

> With respect to the rules regarding public notice, it was our policy, at the time TN 84-36 was adjudicated, that any amendment that constituted a significant change in the plan's methods and standards for determining payment rates was considered a 'significant amendment' and was required to be accompanied by the assurances and related information required

> by the Federal regulations at 42 C.F.R. 447.253 and .255. One of the required assurances concerned compliance with the public notice rules at 447.205. This rule in turn, required publication of a public notice for 'any significant proposed change' in the State's methods and standards. While the determination of significance was generally within the realm of discretion accorded to the states, that determination was subject to Federal review.

Appendix L, p. 78a.

On June 23, 1989, the district court entered an order joining the Secretary of the United States Department of Health and Human Services as a party defendant necessary for a just and complete adjudication of this cause. Subsequently, all parties filed motions for summary judgment or motions to dismiss or, in the alternative, for summary judgment. In their motions, the Defendants contended that 84-36 came within the public notice exception found at 42 C.F.R. 447.205(b) (1), since they alleged it was a change made to conform to Medicare levels of reimbursement. A hearing was held before the United States District Court for the Southern District of Mississippi on all motions on January 19, 1990.

At the hearing, MCHA's expert witness was Dr. Robert Deane, the Chief Economist of the American Health Care Association who has assisted several states in drafting Medicaid reimbursement plans. Dr. Deane refuted the Defendants' arguments that 84-36 was adopted to conform to Medicare methods or levels of reimbursement. Dr. Deane testified that certain aspects of 84-36 "wouldn't meet the exception [42 C.F.R.

§ 447.205(b) (1)] in its most liberal interpretation." (R. Vol. VII, p. 39).[4] Dr. Deane found many provisions of 84-36 to be more restrictive than Medicare principles and stated that the § 447.205(b) (1) exception from public notice was not intended to be applied to plan amendments designed to accommodate a major piece of federal litigation. Rather, the exception was intended to allow states to make slight changes in their reimbursement provisions from year to year in order to comply with the upper limits test. Dr. Deane warned that applying the public notice exception to 84-36 would give states "basically a license to hunt around within the Medicare principles and make all kinds of changes without requirement for public notice. . . . " (R. Vol. VII, pp. 21-22).

On March 2, 1990, the United States District Court for the Southern District of Mississippi rendered an opinion granting the Plaintiffs' motions for summary judgment and denying the motions of the Defendants. Appendix C, p. 22a. In so doing, the district court noted that "[i]t was recognized by the federal agency approving the plan that the amendment constituted a 'significant change.' The plan itself is recognized by all parties involved as being more restrictive than DEFRA and, thus, clearly was not in compliance with that Act but was beyond what the Act provided for."[5] Appendix C, p. 33a. A Final Judgment

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[4] Cite is to the Fifth Circuit record.

[5] The Consolidated Omnibus Reconciliation Act (COBRA) became effective on October 1, 1985. COBRA's provisions for Medicare reimbursement were even less restrictive than those set forth in DEFRA. If the provisions of 84-36 were more restrictive than Medicare principles before COBRA was enacted, they were even more so after October 1, 1985.

was entered by the district court on March 12, 1990, and DOM ultimately filed a timely appeal with the United States Court of Appeals for the Fifth Circuit.[6]

The Fifth Circuit rendered an opinion on April 11, 1991, reversing the district court's decision and remanding the case for further action on the Defendants' motions for summary judgment consistent with the Fifth Circuit opinion. See Appendix B, p. 10a. MHCA filed a petition for rehearing on April 25, 1991. The petition for rehearing was granted by the Fifth Circuit on July 16, 1991, and, on the same date, the Fifth Circuit replaced its prior opinion with a new opinion which again reversed the district court's decision and remanded the case for further action consistent with its opinion. See Appendix A, p. 1a. In its July 16, 1991 opinion, the Fifth Circuit based its reversal, at least in part, on the fact that "DOM certainly *intended* 84-36 to bring Mississippi's plan closer into sync with the Medicare methods and reimbursement levels – which may well be all that § 447.205(b)(1) requires. [Footnote omitted]" Appendix A, pp. 8a-9a. The Fifth Circuit also rejected the district court's findings that 84-36 was more restrictive than the Medicare requirements set forth under DEFRA. The Fifth Circuit noted that, in some instances, Plan Amendment 84-36 resulted in Medicaid payments in excess of that permitted under DEFRA Medicare provisions. Appendix A, p. 8a.[7]

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[6] HCFA did not challenge the district court's decision by filing an appeal to the Fifth Circuit.

[7] Subsequent SPECTRUM reviews revealed that, although theoretically more restrictive than DEFRA, Mississippi's plan

(Continued on following page)

ARGUMENT

REASONS FOR GRANTING THE WRIT

The Fifth Circuit's July 16, 1991 opinion establishes a dangerous precedent which could be used by states nationwide to circumvent the purposes and effect of the public notice requirements of 42 C.F.R. § 447.205. The instant case provides an appropriate opportunity for this Court to settle this question of federal law and prevent the contravention of the critical public notice requirements.

Once it became apparent in this litigation that certain provisions of Transmittal No. 84-36 were more restrictive, at least in theory, than DEFRA requirements [and, therefore, Medicare levels of reimbursement], DOM maintained that, even if such were the case, public notice would not be required. DOM's position was based on its theory that if the provisions of 84-36 provided for payments either equal to or more restrictive than the Medicare upper limits, then the provisions complied with Medicare and no public notice would be required. On the

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(Continued from previous page)

had in certain situations resulted in excess payments being made to providers over and above what DEFRA allowed. (See SPECTRUM review and correspondence at Appendix M, p. 80a and Appendix N, p. 87a). There has been some confusion regarding why the plan resulted in excess payments. Although an original SPECTRUM review cited State accounting procedures as a reason, the revised SPECTRUM review cited the method by which DOM computed reimbursement following a change in ownership as a cause. Appendix N, p. 89a.

other hand, the Fifth Circuit placed great importance on the fact that, when implemented, certain provisions of 84-36 actually "resulted in Medicaid payments in *excess* of those permitted under the DEFRA Medicare provisions." Appendix A, p. 8a. According to the Fifth Circuit decision, if payments are in excess of (and therefore less restrictive than) those allowed by Medicare, then no public notice is required. Reading the theories of DOM and the Fifth Circuit together, the result is that public notice is never required for a significant change in a state's Medicaid reimbursement plan, and the public notice requirements of 42 C.F.R. § 447.205 have absolutely no force and effect.

Even if the Fifth Circuit had acknowledged that provisions which were more restrictive than Medicare requirements could only be adopted after public notice – and there is no indication that the Fifth Circuit acknowledged such a fact – its decision establishes dangerous precedent for three reasons. First, the Fifth Circuit held that since 84-36 allowed, for whatever reason, payments in excess of Medicare limits, then the public notice exception was invoked and no public notice was required before implementation. The Fifth Circuit's position is clearly erroneous since it suggests that a plan which provides for payments in excess of Medicare limits "[c]onforms to Medicare methods or levels of reimbursement." If a plan amendment allows for payments exceeding Medicare requirements, then that plan does not conform to Medicare limits and should not be exempt from public notice under 42 C.F.R. § 447.205(b)(1).

The second dangerous precedent established by the Fifth Circuit's July 16, 1991 opinion is the fact that the Fifth Circuit placed greater emphasis on the effect of

84-36 *after* implementation than on the fact that 84-36 was theoretically more restrictive than DEFRA requirements when adopted. Such a precedent could be used by states nationwide to take a wait-and-see approach to significant plan amendments, adopting and implementing them without notice first and then considering the actual effects on reimbursement levels. The purpose of public notice is to provide providers with knowledge of a plan amendment *before* they are affected by it. To allow states to adopt plans without notice and then later make a determination as to the precise effect on reimbursement levels would obviously circumvent the public notice requirements. A decision should be made with regard to public notice before a plan is implemented. The Fifth Circuit's opinion erroneously suggests that the restrictiveness of a plan in theory at the time of adoption can be discarded in consideration of the actual effects of a plan once it is already implemented. Such a practice would make public notice, which should be made before implementation of the plan amendment if required, useless.

The third dangerous precedent which the Fifth Circuit establishes in its opinion involves the Fifth Circuit's reliance on what it perceived to be DOM's *intent* to conform to Medicare levels of reimbursement in adopting 84-36. The Fifth Circuit stated, "Finally, as the correspondence between HCFA and DOM indicates, DOM certainly *intended* 84-36 to bring Mississippi's plan closer into sync with Medicare methods and reimbursement levels – which may well be all that § 447.205(b)(1) requires." Appendix A, pp. 8a-9a. The danger in replacing objective analyses of plan amendments and their anticipated effect on reimbursement levels with consideration of a state's

subjective intent in determining whether public notice is required is apparent. The Fifth Circuit's decision opens the door for states to avoid public notice obligations for significant changes in plan amendments by claiming that the intent was to conform to Medicare, even though the actual effect may be otherwise.

In its July 16, 1991 decision, the Fifth Circuit reversed a district court decision which was sound and well-reasoned. The district court correctly concluded that certain provisions of 84-36 were in theory more restrictive than Medicare requirements and that public notice was required before implementation. With regard to re-evaluation of assets, even the Fifth Circuit admits that 84-36, unlike Medicare requirements, contained "a few extra provisions that DOM believed would further restrain any upward re-evaluation in nursing home value, such as a provision that, for purposes of determining a new owner's interest expense, precluded a new owner from treating as indebtedness any amount greater than the indebtedness that saddled the old owner as of the sale date." Appendix A, p. 5a. Nevertheless, since actual payments made exceeded Medicare levels, for reasons which are not altogether clear, the Fifth Circuit held that public notice was not required. Confusingly, the Fifth Circuit stated that "[a]dditionally, even if 84-36 is in theory more strict than the correlative Medicare subparagraph, the two are functional equivalents given that, as previously noted, reimbursements under 84-36 have been greater than Medicare permits." Appendix A, p. 8a. The district court was correct in considering the restrictiveness of the provisions compared to Medicare at the time of adoption rather than considering the effects of 84-36 after implementation

to determine whether public notice was required before implementation.

With regard to recapture of depreciation, the Fifth Circuit stated that "84-36 is a carbon copy of the DEFRA Medicare recapture provision; the two differ not in the slightest." Appendix A, p. 8a. As maintained in MHCA's petition for rehearing, the Fifth Circuit's position with regard to recapture of depreciation is clearly erroneous. DEFRA provided that when recapturing depreciation, states were to continue to use the method in place as of June 1, 1984. Appendix D, p. 35a. The recapture provisions which were in effect on June 1, 1984, are discussed in *Mercy Community Hospital v. Heckler*, 781 F.2d 1552 (11th Cir. 1986). In that case, the Eleventh Circuit discussed 42 C.F.R. § 405.415(f), and stated:

> Although that regulation required that gains and losses realized on the disposal of a depreciated asset be included in determining reimbursable costs, *neither it nor any other regulation specified the appropriate procedure for computing the relevant gain or loss or the appropriate method for making retroactive adjustments to allowances already paid for depreciation.*

781 F.2d at 1556 (emphasis added). Federal law in effect on June 1, 1984, provided that depreciation could be recaptured, but did not provide for a specific method of recapture. Even if Transmittal No. 84-36 did comply with Medicare requirements, it was not adopted "to conform to Medicare methods or levels of reimbursement" since 84-9 had also complied with Medicare requirements. DEFRA did not mandate a change in recapture provisions for the status quo. As such, 84-36's elimination of the recapture phase-out provisions contained in 84-9 was

subject to public notice and the Fifth Circuit's holding was clearly erroneous.[8]

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[8] Additionally, the Fifth Circuit, in its July 16, 1991 opinion, abandoned the position in its April 11, 1991 opinion that HCFA's actions in approving 84-36 were entitled to judicial deference. In the April 11, 1991 opinion, the Fifth Circuit had relied heavily on its perception that HCFA had rendered an official agency interpretation of the regulation finding that no public notice was required. On its petition for rehearing, MHCA pointed out that HCFA had never specifically stated that no public notice was required and, in fact, had presented conflicting positions with regard to whether public notice was required. In its petition, MHCA cited authorities supporting its position that HCFA's actions could not be construed as an official agency interpretation entitled to judicial deference. MHCA also cited authorities supporting its position that the affidavit of Bernard J. Truffer, Chief of the Special Payment Programs Branch in the Division of Alternative Payment Systems at HCFA, executed after litigation began, was not an official agency interpretation. *See, e.g., In re Chateaugay Corp.*, 118 B.R. 19, 23 (Bkrtcy. S.D.N.Y. 1990) ("The affidavit submitted by Timothy K. Scherkenbach, Director of the agency's Division of Water Quality, is unpersuasive and concededly does not constitute an official position of the Agency Board.") (Emphasis in original). MHCA also cited authorities supporting its position that HCFA officials' statements after litigation began that public notice was not required were merely agency litigation posturing which was not entitled to deference. *See. e.g., Chevron v. NRDC*, 467 U.S. 837 (1984); *Church of Scientology of Cal. v. IRS*, 792 F.2d 153 (D.C. Cir. 1986) (en banc) *aff'd* 484 U.S. 9 (1987); *Ames v. Merrill Lynch Pierce Fenner & Smith*, 567 F.2d 1174, 1177 n.3 (2nd Cir. 1977). *See also Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985) (approval by HCFA does not preclude a challenge to a state plan). Since the Fifth Circuit, in its July 16, 1991 opinion, deleted any references of judicial deference to HCFA's actions, it appears that MHCA's arguments regarding this point were well-taken.

The basic unfairness of the adoption of 84-36 without public notice is best demonstrated by consideration of its effect on certain providers who sold facilities between the time that 84-36 became effective and the time that MHCA learned of the plan amendment and informed its members. Many of those providers sold the facilities, believing that they would not be subject to recapture of liability under 84-9's forgiveness provisions. Instead, since 84-36 was in effect without the knowledge of providers, many of those providers selling facilities incurred substantial liability for recaptured depreciation. The fact that providers made significant business decisions without knowledge of liabilities which would be incurred as a result of those decisions, best demonstrates the purpose of the public notice requirements. Because of DOM's failure to provide notice, the providers were deprived of property without due process and notice.

The Plaintiffs' knowledgeable expert, Dr. Robert T. Deane, testified at the hearing before the district court that the public notice exception was not intended to apply to major plan amendments drafted in response to federal legislation. At the hearing, Dr. Deane testified as follows:

> Now in order for a state to comply with that what is now referred to as the Medicare upper limits test, which has been put in regulation based upon that conference report put in regulation by HCFA, in order for a state to comply, they may have to from time to time tweak their system a little bit, change some of the parameters of the system from year-to-year to make sure it complies with the upper limits test.

> Q. Have you had personal experience with that application?
>
> A. Oh, yes. As a matter of fact, when I designed the Maryland system, I had to tweak it considerably to get it to comply with that limitation in the first year of its operation. But other states do it as well.
>
> And I am sure that this regulation, the change as being made to conform to Medicare methods or levels of reimbursement refers to the annual actions that states may have to take to change their reimbursement methodology or reimbursement amount in order to comply annually with this upper limits test, and was not designed in 1981 to handle a piece of federal legislation that was passed in 1984 or 1987 or 1988.

R. Vol. VII, pp. 21-22. It cannot be contended that 84-36 contained the sort of minor plan adjustments envisioned by the § 447.205(b)(1) exception.

CONCLUSION

The United States Supreme Court has not settled this question of federal law, and the instant case provides an appropriate opportunity for this Court to do so. For these reasons, the writ of certiorari should be granted.

Respectfully submitted,

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October 14, 1991

APPENDIX A

INDEPENDENT NURSING HOME ASSOCIATION,

Plaintiff-Appellee,

v.

J. Clinton SMITH, M.D., in his official capacity as Director of the State of Mississippi Division of Medicaid in the Office of the Governor, Defendant-Appellant.

MISSISSIPPI HEALTH CARE ASSOCIATION, Plaintiff-Appellee,

v.

J. Clinton SMITH, M.D. in his official capacity as Director of the State of Mississippi Division of Medicaid in the Office of the Governor, Defendant-Appellant.

No. 90-1382.

United States Court of Appeals,
Fifth Circuit.

July 16, 1991.

Appeal from the United States District Court for the Southern District of Mississippi.

ON PETITION FOR REHEARING*

(Opinion April 11, 1991, 5th Cir.1991, 928 F.2d 181)

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* The plaintiff-appellee, Independent Nursing Home Association, has filed a petition for rehearing challenging our decision and opinion dated April 11, 1991. The petition for rehearing is granted and our earlier opinion has been withdrawn and the following opinion has been entered in its place.

Before WISDOM, KING, and JOLLY, Circuit Judges.

E. GRADY JOLLY, Circuit Judge:

J. Clinton Smith, Director of the Mississippi Division of Medicaid (hereinafter "DOM"), appeals from a judgment below that permanently enjoins him from enforcing a 1984 amendment to Mississippi's state Medicaid plan. The district court issued the injunction on the basis that the 1984 amendment was passed without public notice, ostensibly required under 42 CFR § 447.205(a); Smith argues that the amendment fell within an exception to § 447.205(a) and that, therefore, public notice was unnecessary. We find ourselves in agreement with Smith and thus reverse.

I

The facts that underpin this appeal are somewhat more esoteric than most. DOM is the Mississippi agency responsible for implementing the state's Medicaid program. Like similar agencies in other states, DOM receives a federal subsidy for its Medicaid efforts so long as its Long-Term Care Reimbursement Plan complies with federal requirements. The Health Care Financing Administration division of the Department of Health and Human Services ("HCFA") is the federal agency that oversees state Medicaid plans; as such, HCFA approval of a state's plan – and any amendment thereto – is a prerequisite to the aforementioned federal financial assistance.

In mid-1984, Congress passed the Deficit Reduction Act ("DEFRA"), § 2314 of which modified the federal financial assistance requirements for both Medicare and

Medicaid. In the only modification pertinent to this appeal, DEFRA limited the amount of Medicare and Medicaid payments that states could pay out upon the sale or transfer of a nursing home facility. The Medicare amendment took the guise of a subparagraph (O) appended by § 2314 to 42 U.S.C. § 1395x(v)(1) (Supp. 1985): It provided (1) that a transferred nursing home must be "re-evaluated" at a cost no higher than the lesser of the acquisition cost paid by the record owner as of July 18, 1984, and the new owner's acquisition cost (*i.e.*, the purchase price); and (2) that when "recapturing" depreciation from the nursing home transferor, the government was to continue to use the method in place as of June 1, 1984. As for the limitations on Medicaid payments, § 2314 effected these by amending 42 U.S.C. § 1396a(a)(13)(B) (Supp. 1985) to read as follows:

> (a) Contents. A State plan for medical assistance must –
>
> * * *
>
> (13) Provide –
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> * * *
>
> (B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals, skilled nursing facilities, and intermediate care facilities can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of [42 U.S.C. § 1395x(v)(1)(O).];

Thus, after DEFRA, a state could guarantee federal funding for its Medicaid work only if it could adequately

assure that, in the event of a nursing home transfer, its plan would mete out to the new owner no more of a payment increase than was permissible under Medicare generally and 42 U.S.C. § 1395x(v)(1)(O) specifically.[1]

The adjustments brought on by DEFRA spurred HCFA into action. By letter dated August 30, 1984, it advised DOM of DEFRA's passage and recommended that DOM review its plan in order "to ensure [that it] does not result in capital payments that might exceed the new requirements." Unsurprising, DOM did just that, concluding that its plan, itself recently amended by Transmittal 84-9, required further modification if it were to comply with the dictates of 42 U.S.C. § 1396a(a)(13)(B). Accordingly, DOM drafted a new plan amendment, Transmittal 84-36, which in November 1984 it submitted to HCFA for approval.

Essentially, Transmittal 84-36 wrought only two changes, both of which were substantively similar to the Medicare changes made by 42 U.S.C. § 1395x(v)(1)(O). First, 84-36 recast DOM's "re-evaluation" of assets formula for nursing home transfers. Under Transmittal 84-9, the value of a nursing home to the new owner was, roughly speaking, the lesser of (1) its purchase price, (2) its fair market value, and (3) the sum of its historical depreciable basis prior to sale and a (variable) portion of the difference between that basis and the home's fair

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[1] Although of no bearing to our disposition of this appeal, we note that the plaintiffs, Smith, DOM, and HCFA seem to have interpreted the DEFRA amendment to 42 U.S.C. § 1396a(a)(13)(B) as also requiring that states recapture Medicaid-paid depreciation in accordance with Medicare principles.

market value. The Transmittal 84-36 method – like the new Medicare method – relegated the new owner to the lower of his purchase price and the acquisition cost borne by the July 18, 1984 record owner. Unlike the 42 U.S.C. § 1395x(v)(1)(O) formula, however, 84-36 included a few extra provisions that DOM believed would further restrain any upward re-evaluation in nursing home value, such as a provision that, for purposes of determining a new owner's interest expense, precluded a new owner from treating as indebtedness any amount greater than the indebtedness that saddled the old owner as of the sale date. Second, DOM's Transmittal drastically altered its plan sections that dealt with "recapture of depreciation," junking the 84-9 system in favor of the very method that DEFRA mandated for Medicare.

On December 27, 1984, HCFA made several written "comments" regarding 84-36 and notified DOM that it was suspending review of the Transmittal pending DOM's response to these comments. One such comment presumably was proffered out of concern that DOM had misconstrued the impact of DEFRA on state Medicaid plans:

> . . . The State should be advised that although it may adopt the Medicare provision as specified at section 1861(v)(1)(O), the Medicaid statute only mandates a limit on the *increase* in the amount a State is allowed to pay for specified capital costs as a result of a change in ownership. The Medicaid statute does not require that the Medicare provisions be adopted by each State and does not mandate a specific methodology that must be used for the revaluation of assets. [Emphasis in original.]

This exhortation notwithstanding, DOM opted to make only minor, unimportant adjustments to its original draft of 84-36. It then submitted this slightly reconstituted version of 84-86 for HCFA sanction, which it received on May 1, 1985.

DOM did not, however, provide public notice before incorporating Transmittal 84-36 into its Medicaid plan. Although a regulation – promulgated and enforced by HCFA – ordinarily requires Medicaid agencies to "provide public notice of any significant change in its methods and standards for setting payment rates for services," 42 CFR § 447.205(a), an HCFA official advised DOM that 84-36 fell within the exception to § 447.205(a) codified at 42 CFR § 447.205(b) and thus demanded no such notice:

> (b) *When notice is not required.* Notice is not required if –
>
> (1) The change is being made to conform to Medicare methods or levels of reimbursement;
>
> (2) The change is required by the court order; or
>
> (3) The change is based on changes in wholesalers' or manufactures' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

Some years later, the Independent Nursing Home Association and the Mississippi Health Care Association (comprising between them over 130 Mississippi nursing homes) filed the instant suit, seeking *inter alia* injunctive

relief barring the enforcement of 84-36.[2] As support for their position, the plaintiffs alleged that DOM's failure to comply with § 447.205(a)'s notice requirement rendered 84-36 unenforceable; Smith and HCFA (joined as a party defendant) countered by arguing that 84-36 fell within the § 447.205(b) exception generally and the § 447.205(b)(1) exception specifically, thus rendering notice optional rather than obligatory. After receiving cross motions for summary judgment and conducting a hearing, the district court on March 12, 1990 granted the plaintiffs' motion and entered judgment in their favor. This timely appeal ensued.

II

If this appeal poses facts bordering on the arcane, its legal puzzle is far less daunting. The disagreement here centers around but one issue: whether Transmittal 84-36 fell within the public notice exception of § 447.205(b)(1). The district court concluded that 84-36 was subject to the notice stricture because, in its words, "the state's plan [as amended by the Transmittal] is more restrictive than the [Medicare] requirements set forth under DEFRA."

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[2] In 1987, DOM submitted Transmittal 87-8 to HCFA, which contains all the substantive provisions found in plan amendment 84-36. Unlike 84-36, however, 87-8 was accompanied by public notice. HCFA approved 87-8 on July 7, 1987 and assigned it an effective date of April 1, 1987.

As the foregoing should make clear, this suit questions the validity of plan amendment 84-36, effective from October 1, 1984 to April 1, 1987. It raises no questions about the viability of Transmittal 87-8.

We disagree. As an initial matter, the trial court's premise – that 84-36 was more restrictive than the Medicare amendments of 42 U.S.C. § 1395x(v)(1)(O) – appears somewhat dubious. With respect to depreciation, 84-36 is a carbon copy of the DEFRA Medicare recapture provisions; the two differ not in the slightest. As for re-evaluation of assets, the district court acknowledged that DOM's plan amendment has resulted in Medicaid payments in *excess* of those permitted under the DEFRA Medicare provisions.[3] Hence, the finding below that 84-36 was somehow more unkind to nursing home transfers than were comparable Medicare standards seems undermined by reality.

What is more, DOM's plan change was indeed, "made to conform to Medicare *methods or levels of reimbursement.*" 42 CFR § 447.205(b)(1) (emphasis added). As amended by 84-9, the predecessor plan neither used Medicare methods nor reimbursed at Medicare levels. In contrast, 84-36 and 42 U.S.C. § 1395x(v)(1)(O) share recapture provisions and utilize reevaluation methods that are similar if nothing else. Additionally, even if 84-36 is in theory more strict then the correlative Medicare subparagraph, the two are functional equivalents given that, as previously noted, reimbursements under 84-36 have been greater than Medicare permits. Finally, as the correspondence between HCFA and DOM indicates, DOM certainly *intended* 84-36 to bring Mississippi's plan closer into sync

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[3] DOM is responsible, of course, for reimbursing to HCFA the excess Medicaid payments.

with Medicare methods and reimbursement levels – which may well be all that § 447.205(b)(1) requires.[4]

III

In keeping with the foregoing, we hold that Transmittal 84-36 fell within the public notice exception of § 447.205(b)(1). We therefore reverse the judgment of the district court and vacate the order enjoining Smith from enforcing 84-36. We remand this cause to the district court for further proceedings not inconsistent with this opinion, including appropriate action upon Smith's motion for summary judgment.

REVERSED and REMANDED.

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[4] Again, the regulation states that notice is not required if *"[t]he change is being made to conform* to Medicare methods or levels of reimbursement." 42 CFR § 447.205(b) (emphasis added).

APPENDIX B

INDEPENDENT NURSING HOME ASSOCIATION, Plaintiff-Appellee,

v.

J. Clinton SMITH, M.D., in his Official Capacity as Director of the State of Mississippi Division of Medicaid in the Office of the Governor, Defendant-Appellant.

MISSISSIPPI HEALTH CARE ASSOCIATION, Plaintiff-Appellee,

v.

J. Clinton SMITH, M.D., in his Official Capacity as Director of the State of Mississippi Division of Medicaid in the Office of the Governor, Defendant-Appellant.

No. 90-1382.

United States Court of Appeals,
Fifth Circuit

April 11, 1991.

Appeal from the United States District Court for the Southern District of Mississippi.

Before WISDOM, KING, and JOLLY, Circuit Judges.

E. GRADY JOLLY, Circuit Judge:

J. Clinton Smith, Director of the Mississippi Division of Medicaid (hereinafter "DOM"), appeals from a judgment below that permanently enjoins him from enforcing a 1984 amendment to Mississippi's state medicaid plan. The district court issued the injunction on the basis that the 1984 amendment was passed without public notice, ostensibly required under 42 CFR § 447.205(a); Smith

argues that the amendment fell within an exception to § 447.205(a) and that, therefore, public notice was unnecessary. We find ourselves in agreement with Smith and thus reverse.

I

The facts that underpin this appeal are somewhat more esoteric than most. DOM is the Mississippi agency responsible for implementing the state's Medicaid program. Like similar agencies in other states, DOM receives a federal subsidy for its Medicaid efforts so long as its Long-Term Care Reimbursement Plan complies with federal requirements. The Health Care Financing Administration division of the Department of Health and Human Services ("HCFA") is the federal agency that oversees state Medicaid plans; as such, HCFA approval of a state's plan – and any amendment thereto – is a prerequisite to the aforementioned federal financial assistance.

In mid-1984, Congress passed the Deficit Reduction Act ("DEFRA"), § 2314 of which modified the federal financial assistance requirements for both Medicare and Medicaid. In the only modification pertinent to this appeal, DEFRA limited the amount of Medicare and Medicaid payments that states could pay out upon the sale or transfer of a nursing home facility. The Medicare amendment took the guise of a subparagraph (O) appended by § 2314 to 42 U.S.C. § 1395x(v)(1)(Supp. 1985): It provided (1) that a transferred nursing home must be "re-evaluated" at a cost no higher than the lesser of the acquisition cost paid by the record owner as of July 18, 1984, and the new owner's acquisition cost (*i.e.*, the purchase price);

and (2) that when "recapturing" depreciation from the nursing home transferor, the government was to continue to use the method in place as of June 1, 1984. As for the limitations on Medicaid payments, § 2314 effected these by amending 42 U.S.C. § 1396a(a)(13)(B)(Supp.1985) to read as follows:

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Thus, after DEFRA, a state could guarantee federal funding for its Medicaid work only if it could adequately assure that, in the event of a nursing home transfer, its plan would mete out to the new owner no more of a payment increase than was permissible under Medicare generally and 42 U.S.C. § 1395x(v)(1)(O) specifically.[1]

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[1] Although of no bearing to our disposition of this appeal, we note that the plaintiffs, Smith, DOM, and HCFA seem to have interpreted the DEFRA amendment to 42 U.S.C. § 1396a(a)(13)(B) as also requiring that states recapture Medicaid-paid depreciation in accordance with Medicare principles.

The adjustments brought on by DEFRA spurred HCFA into action. By letter dated August 30, 1984, it advised DOM of DEFRA's passage and recommended that DOM review its plan in order "to ensure [that it] does not result in capital payments that might exceed the new requirements." Unsurprisingly, DOM did just that, concluding that its plan, itself recently amended by Transmittal 84-9, required further modification if it were to comply with the dictates of 42 U.S.C. § 1396a(a)(13)(B). Accordingly, DOM drafted a new plan amendment, Transmittal 84-36, which in November 1984 it submitted to HCFA for approval.

Essentially, Transmittal 84-36 wrought only two changes, both of which were substantively similar to the Medicare changes made by 42 U.S.C. § 1395x(v)(1)(O). First, 84-36 recast DOM's "re-evaluation" of assets formula for nursing home transfers. Under Transmittal 84-9, the value of a nursing home to the new owner was, roughly speaking, the lesser of (1) its purchase price, (2) its fair market value, and (3) the sum of its historical depreciable basis prior to sale and a (variable) portion of the difference between that basis and the home's fair market value. The Transmittal 84-36 method – like the new Medicare method – relegated the new owner to the lower of his purchase price and the acquisition cost borne by the July 18, 1984 record owner. Unlike the 42 U.S.C. § 1395x(v)(1)(O) formula, however, 84-36 included a few extra provisions that DOM believed would further restrain any upward re-evaluation in nursing home value, such as a provision that, for purposes of determining a new owner's interest expense, precluded a new owner from treating as indebtedness any amount greater than

the indebtedness that saddled the old owner as of the sale date. Second, the DOM's Transmittal drastically altered its plan sections that dealt with "recapture of depreciation," junking the 84-9 system in favor of the very method that DEFRA mandated for Medicare.

On December 27, 1984, HCFA made several written "comments" regarding 84-36 and notified DOM that it was suspending review of the Transmittal pending DOM's response to these comments. One such comment presumably was proffered out of concern that DOM had misconstrued the impact of DEFRA on state Medicaid plans:

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This exhortation notwithstanding, DOM opted to make only minor, unimportant adjustments to its original draft of 84-36. It then submitted this slightly reconstituted version of 84-36 for HCFA sanction, which it received on May 1, 1985.

DOM did not, however, provide public notice before incorporating Transmittal 84-36 into its Medicaid plan. Although a regulation – promulgated and enforced by

HCFA – ordinarily requires Medicaid agencies to "provide public notice of any significant change in its methods and standards for setting payment rates for services," 42 CFR § 447.205(a), HCFA advised DOM that 84-36 fell within the exception to § 447.205(a) codified at 42 CFR § 447.205(b) and thus demanded no such notice:

> (b) *When notice is not required.* Notice is not required if –
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> (2) The change is required by the court order; or
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> (3) The change is based on changes in wholesalers' or manufactures' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

Some years later – and after continued reassurances by HCFA that public notice of Transmittal 84-36 was unnecessary – the Independent Nursing Home Association and the Mississippi Health Care Association (comprising between them over 130 Mississippi nursing homes) filed the instant suit, seeking *inter alia* injunctive relief barring the enforcement of 84-36.[2] As support for

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[2] In 1987, DOM submitted Transmittal 87-8 to HCFA, which contains all the substantive provisions found in plan amendment 84-36. Unlike 84-36, however, 87-8 was accompanied by public notice. HCFA approved 87-8 on July 7, 1987 and assigned it an effective date of April 1, 1987.

As the foregoing should make clear, this suit questions the validity of plan amendment 84-36, effective from October 1, 1984 to April 1, 1987. It raises no questions about the viability of Transmittal 87-8.

their position, the plaintiffs alleged the DOM's failure to comply with § 447.205(a)'s notice requirement rendered 84-36 unenforceable; Smith and HCFA (joined as a party defendant) countered by arguing that 84-36 fell within the § 447.205(b) exception, thus rendering notice optional rather than obligatory. After receiving cross motions for summary judgment and conducting a hearing, the district court on March 12, 1990, granted the plaintiffs' motion and entered judgment in their favor. This timely appeal ensued.

II

If this appeal poses facts bordering on the arcane, its legal puzzle is far less daunting. The disagreement here centers around but one issue: whether HCFA properly exercised its discretion in ruling that 84-36 is subject to § 447.205(b)'s public notice exception. The district court thought that HCFA abused its discretion, basing this conclusion on a finding that "the state's plan [as amended by Transmittal 84-36] is more restrictive than the [Medicare] requirements set forth under DEFRA."

We view HCFA's action differently. As an initial matter, the trial court's premise – that 84-36 was more restrictive than the Medicare amendments of 42 U.S.C. § 1395x(v)(1)(O) – appears somewhat dubious. With respect to depreciation, 84-36 is a carbon copy of the DEFRA Medicare recapture provisions; the two differ not in the slightest. As for re-evaluation of assets, the district court acknowledged that DOM's plan amendment has

resulted in Medicaid payments in *excess* of those permitted under the DEFRA Medicare provisions.[3] Hence, the finding below that 84-36 was somehow more unkind to nursing home transfers than were comparable Medicare standards seems undermined by the reality.

More importantly, however, the district court's reliance on the relative strictness of 84-36 and 42 U.S.C. § 1395x(v)(1)(O) is, in the context of this case, largely beside the point. Assuming *arguendo* that 84-36's provisions are theoretically more rigorous than Medicare's, the fact remains that HCFA's application of a regulation that it itself enforces is due considerable deference. " 'The . . . administrative interpretation . . . [is] of controlling weight unless it is plainly erroneous or inconsistent with the regulation.' " *United Steelworkers of America v. Schuylkill Metals*, 828 F.2d 314, 319 (5th Cir. 1987), quoting *Bowles v. Seminole Rock Co.*, 325 U.S. 410, 413-14, 65 S.Ct. 1215, 1217, 89 L.Ed. 1700 (1945). *See also Mississippi Hospital Association, Inc. v. Heckler*, 701 F.2d 511, 516 (5th Cir. 1983) ("The function and expertise of the federal courts in [the] sphere [of Medicaid repayment schemes] is limited . . . "). Judicial review of agency action is "especially" circumscribed where the agency has promulgated the regulation in dispute. *Ford Motor Credit Co. v. Milhollin*, 444 U.S. 555, 100 S.Ct. 790, 63 L.Ed.2d 22 (1980). To be sure, if 84-36 is less permissive than the Medicare reimbursement program, and had HCFA foreclosed DOM from finding refuge in the § 447.205(b) exception, a reviewing court would have been pressed to overturn that interpretation.

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[3] DOM is responsible, of course, for reimbursing to HCFA the excess Medicaid payments.

It is equally clear, however, that the small difference in restrictiveness on which the district court's judgment rests is too minor a difference to support the (necessary) conclusion that HCFA's application of § 447.205(b) is "plainly erroneous or inconsistent with the regulation." *United Steelworkers*, 828 F.2d at 319.

What is more, additional factors support HCFA's conclusion: that DOM's plan change was "made to conform to Medicare methods *or levels of reimbursement*." 42 CFR § 447.205(b) (emphasis added). As amended by 84-9, the predecessor plan neither used Medicare methods nor reimbursed at Medicare levels. In contrast, 84-36 and 42 U.S.C. § 1395x(v)(1)(O) share recapture provisions and utilize re-evaluation methods that are similar if nothing else. Additionally, even if 84-36 is in theory more strict than the correlative Medicare subparagraph, the two are functional equivalents given that reimbursements under 84-36 have been greater than Medicare permits. Finally, as the correspondence between HCFA and DOM indicates, DOM certainly *intended* 84-36 to bring Mississippi's plan closer into sync with Medicare methods and reimbursement levels – which may well be all that § 447.205(b)(1) requires.[4] At base, the district court was in error to

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[4] The regulation states that notice is not required if "*[t]he change is being made to conform* to Medicare methods or levels of reimbursement." 42 CFR § 447.205(b) (emphasis added). Without so deciding, we note that this language can be construed as focusing on the *motive* for the change – here, to conform to Medicare regulations – rather than on the question of whether the change in truth brings Medicaid payment methods and standards into line with Medicare methods and standards.

conclude in the face of these factors that HCFA's understanding of its own regulation was deficient.

III

In keeping with the foregoing, we hold that Transmittal 84-36 fell within the public notice exception of § 447.205(b)(1). We therefore reverse the judgment of the district court and vacate the order enjoining Smith from enforcing 84-36. We remand this cause to the district court for further proceedings not inconsistent with this opinion, including appropriate action upon Smith's motion for summary judgment.

REVERSED and REMANDED.

APPENDIX C

IN THE UNITED STATES COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI JACKSON DIVISION

INDEPENDENT NURSING HOME — PLAINTIFF

VS. — CIVIL ACTION NO. J86-0731(W)

B.F. SIMMONS, in his Official Capacity as Director of the State of Mississippi Division of Medicaid in the Office of the Governor — DEFENDANT

AND

MISSISSIPPI HEALTH CARE COMMISSION — PLAINTIFF

VS. — CIVIL ACTION NO. J86-0765(w)

B.F. SIMMONS, IN HIS OFFICIAL CAPACITY AS DIRECTOR OF THE STATE OF MISSISSIPPI DIVISION OF MEDICAID IN THE OFFICE OF THE GOVERNOR — DEFENDANT

MEMORANDUM OPINION AND ORDER

(Filed Mar. 2, 1990)

The sole issue before the Court is whether the defendant's failure to provide notice pursuant to federal regulation of the amendment to the Mississippi State Medicaid Plan contained in transmittal 84-36 renders this transmittal invalid and unenforceable. All parties have filed motions for summary judgment directed to this issue. On January 19, 1990, the court held a hearing on the Plaintiff's Motion for Summary Judgment; the Defendant's Cross-Motion for Dismissal, or, in the alternative, for Summary Judgment; the Motion of the Secretary of

Health and Human Services, joined as a party defendant, to Dismiss or, in the alternative, for Summary Judgment; and the Plaintiff's Motion for Preliminary Injunction. Following the hearing, the parties announced to the court that negotiations toward settlement were being actively pursued. The parties have since advised the court that settlement is unlikely. Therefore, having heard oral argument of counsel for all parties and the testimony of the witnesses offered in behalf of the parties, and having reviewed the briefs, affidavits as well as other submissions, the court is now prepared to enter its ruling. The court finds that the Motion of the Secretary of Health and Human Services to Dismiss or, in the alternative, for Summary Judgment, is not well taken and is hereby denied. The court further finds that the motion of the plaintiffs for summary judgment is well taken and is hereby granted, and the cross-motion of the defendant for dismissal or, in the alternative, summary judgment is not well taken and is hereby denied. Plaintiff's motion for preliminary injunctive relief is rendered moot upon the filing of this order.

THE PARTIES

The plaintiffs, the Mississippi Health Care Association (hereinafter MHCA) and the Independent Nursing Home Association (hereinafter INHA) are non-profit Mississippi corporations chartered for the purpose of advancing the interests of member nursing homes licensed to operate in the state of Mississippi. MHCA has been designated by its membership, comprising some 102 nursing homes throughout the state, and INHA has been designated by its membership of some 31 nursing homes

as agents empowered to bring the present consolidated lawsuits. The defendant, J. Clinton Smith, M.D., is the director of the State Division of Medicaid (hereinafter DOM) and as such administers the Medicaid Program for the State of Mississippi in accordance with Title XIV of the Social Security Act, 42 U.S.C. §§1396, et seq. J. Clinton Smith is the successor to B.F. Simmons who previously held the post and who was the original defendant in this lawsuit.

BACKGROUND

The Mississippi Medicaid Law, Miss. Code Ann. §§ 43-13-101, et seq., (as amended) establishes a statewide system which is financed through state appropriations and federal matching funds. The state has elected to participate in a cooperative state and federal assistance program administered under the Medicaid Act and its implementing regulations. Under this Act, Mississippi has devised a reimbursement plan which was submitted to the Secretary of the United States Department of Health and Human Services (hereinafter HHS) for approval. Once approval is obtained, a state then becomes entitled to partial reimbursement of funds from the federal government. As earlier mentioned, one aspect of this procedural policy with regard to amendment of such plans is the issue before the court today. The plaintiffs contend that DOM amended its state plan through transmittal 84-36 without complying with the required federal regulations, in particular, the notice requirement pursuant to 42 C.F.R. 447.205 and failed to submit required assurances to the Health Care Financing Administration (hereinafter HCFA) as ordered by 42 C.F.R.

§ 447.253. According to the plaintiffs, this alleged defect in the implementation of the amended plan has prejudiced them in that the guidelines are now more restrictive and have caused an increase of reimbursement levels for depreciable assets upon sale or transfer of nursing home facilities.

In 1984 DOM amended its reimbursement plan through Transmittal 84-9 which amended the methodology used to determine depreciation expenses for long-term care facilities. Public Notice of the changes in 84-9 was provided. Afterwards, the Federal Government passed the Deficit Reduction Act of 1984 (hereinafter DEFRA) which involved substantive changes in the reevaluation of assets. DEFRA amended section 1902(a)(13)(B) of the Social Security Act, 42 U.S.C. § 1396a(a)(13)(B). According to the defendant, in an attempt to bring its state plan into compliance with DEFRA, the state again amended its plan with the issuance of Transmittal 84-36. It is undisputed that public notice was not provided prior to the submission of transmittal 84-36 to the federal agency charged with authority to approve such amendments, the Secretary of the U.S. Department of Health and Human Services through the Health Care Financing Administration. The defendant contends that notice was not required under the applicable federal regulation, arguing that the amendment was but implemented as a means of conforming to "Medicare methods or levels of reimbursement" which under 42 C.F.R. §447.205(b) would exempt the amendment from the notice requirements. Although contending it was not required to do so, in 1987 the defendant resubmitted the substance of 84-36 in transmittal 87-8 and provided the publication notice in

accordance with the provisions of 42 C.F.R. 447.205. Transmittal 87-8 was approved on or about July 7, 1987.

The plaintiffs contend that transmittal 84-36 is unenforceable, ineffective, and invalid based on the failure of DOM to promulgate the plan amendment in compliance with federal regulations. The plaintiffs contend that this transmittal radically changed the method by which allowance for depreciation or capital assets, interest on capital indebtedness and return on capital equity previously were calculated and reimbursed when assets changed hands. Also, plaintiffs contend that substantial changes were made to the recapture of depreciation provision which were contained in transmittal 84-9. Such alterations of state plans, according to the plaintiffs, are not exempt from the federal notice regulations.

ISSUE

The issue before the court is whether the defendant's failure to provide notice of the amendment to the Mississippi State Medicaid Plan contained in transmittal 84-36 renders unenforceable and void DOM's attempt to recapture depreciation above the levels in place prior to 84-36 for the periods between the effective date of 84-36 and the effective date of transmittal 87-8.

OVERVIEW OF APPLICABLE LAW

Title XIX of the Social Security Act, 42 U.S.C. § 1396, et seq., (1974) provides for the establishment of cooperative federal-state programs, commonly known as Medicaid, for the purpose of enabling each state, as far as

practicable under the conditions in each state, to furnish medical assistance to certain individuals whose income and resources are insufficient to meet the costs of necessary medical services. States that elect to participate in the program are eligible to receive funds from the federal government if the state establishes a state plan for medical assistance that comports with statutory and regulatory requirements under the Act. *Alexander v. Choate*, 469 U.S. 287, 105 S.Ct. 712, 83 L.Ed 2d 661 (1985); *Charleston Memorial Hospital v. Conrad*, 693 F.2d 324 (4th Cir. 1982); *Burgess v. Affleck*, 683 F.2d 596 (1st Cir. 1982); *SSM Healthcare System v. Reagan*, 681 F. Supp. 625 (W.D.Mo. 1988); *Colorado Health Care Association v. Colorado Department of Social Services*, 598 F. Supp. 1400 (D.Col. 1984), aff'd, 842 F.2d 1158 (10th Cir. 1988). The program is administered by each state in accordance with a state plan that must be approved by the Secretary of Health and Human Services, specifically by the Health Care Financing Administration. The Health Care Financing Administration (hereinafter HCFA) is a part of the Department of Health and Human Services (HHS) and is responsible for approving state medicaid plans. *Nebraska Health Care Association v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), cert. den., 479 U.S. 1063, 107 S.Ct. 947, 93 L.Ed. 2d 996 (1987). Although participation in the program is voluntary, once a state chooses to participate the state must comply with federal statutory requirements. *Mississippi Hospital Association, Inc. v. Heckler*, 701 F.2d 511 (5th Cir. 1983). HCFA's review of state plans is of a cursory nature. "In essence, its review is limited to whether the documentation submitted by the State Medicaid Agency complies with

procedural requirements". *Amisub (PSL) v. Colorado Department of Social Services*, 879 F.2d 789 (10th Cir. 1989).

Here, plaintiff complains that the defendant failed in its state plan to give satisfactory assurances pursuant to 42 C.F.R. § 447.253[1] that public notice under 42 C.F.R. § 447.205[2] was not required before defendant promulgated transmittal 84-36.

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[1] (a) State assurances. In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

* * *

(f) Public notices. The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

[2] (a) When notice is required. Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

(b) When notice is not required. Notice is not required if

(1) The change is being made to conform to Medicare methods or levels of reimbursement;

(2) The change is required by court order; or

(Continued on following page)

In order to secure approval of a state plan, the state agency is to make "assurances" "satisfactory to the Secretary" that certain findings have been made. *Mary Washington Hospital Inc. v. Fisher,* 635 F.Supp. 891 (E.D.Va. 1985). Providing such assurances "is not intended to be burdensome and replaces a previously stricter requirement that the state's methods and standards be 'reviewed and approved' by the Secretary." *Mississippi Hospital Association, Inc. v. Heckler,* 701 F.2d at 520. Moreover, "probing beyond the bottom line to the underlying rate setting methodology is not required under the new standard." *Coalition of Michigan Nursing Homes, Inc. v. Dempsey,* 537 F. Supp. 451 (E.D. Mich. 1982). *Also see Mississippi Hospital Association v. Heckler,* 701 F.2d at 521.

The role of HCFA is to ensure that the states submitting the plan amendments comply with the regulations by providing assurances: the agency had no obligation to independently evaluate the accuracy of the state's determination of efficient and economical operations. However, a state's failure to provide the requisite findings, assurances, and additional information with regard to the modification of reimbursement rates under a state Medicaid plan invalidates those modified rates and the state statute under which they were established. *Hillhaven Corporation v. Wisconsin Department of Health,* 634 F. Supp. 1313 (E.D. Wis. 1986).

(Continued from previous page)

(3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

Approval by HCFA does not necessarily mean that the state plan is protected from any challenge of invalidity. In *Mary Washington Hospital v. Fisher*, 635 F. Supp. at 898, where HCFA was satisfied with the state's amended plan and assurances, the court observed nevertheless:

> [t]he plaintiff is apparently correct in its contention that at least one of the assurances given to HCFA (regarding the appeals process) was in error. This fact detracts from any weight that HCFA's resultant approval of the plan might otherwise have carried with the Court.

Also see West Virginia University Hospitals, Inc. v. Case, 701 F. Supp. 496, 514 (M.D. Pa. 1988), affirmed in part, reversed in part, and vacated on other grounds, 885 F.2d 11 (3rd Cir. 1989), wherein it was argued that HCFA approval of a certain program demonstrated its validity. The court said:

> However, HCFA admits it did not examine DPW's assurances for accuracy or truthfulness or for anything. It merely accepted DPW's statements at face value. This in and of itself would not necessarily undermine DPW's assertion that government approval demonstrates validity, but the fact that the assurances are based only on in-state hospitals does lessen considerably any weight that HCFA's resultant approval of the plan might otherwise have carried with the Court.

Mary Washington Hospital, 635 F. Supp. at 898.

The standard of review which accompanies judicial review of these matters is well recognized. In *Mississippi*

Hospital Association v. Heckler, 701 F.2d 511, 516 (5th Cir. 1983):

> the function and expertise of the federal courts in this sphere is limited, and our role does not extend to reweighing or rethinking the political and financial concerns behind a particular payment plan. A district court can, of course, decide whether federal law has been violated. Otherwise, its review of nonadjudicatory federal agency action is limited to deciding whether the action is arbitrary or capricious . . . . A presumption of validity attaches to agency action, and the burden of proof rests with the party challenging such action . . . [a] district court is entitled to review the actions of a state agency administering federal Medicaid funding as it would review the actions of a federal agency.

With regard to the presumption of the validity of an administrative agency, *also see Alabama Nursing Home Association v. Harris*, 617 F.2d 388 (5th Cir. 1980); *Friedman v. Perales*, 668 F. Supp. 216 (S.D. N.Y. 1987), aff'd, 841 F.2d 47 (2nd Cir. 1988). Under review by the courts, "the Secretary's interpretation of his own regulations and his determination that a state's action conforms to them is entitled to deference." *Coalition of Michigan Nursing Homes v. Dempsey, supra*. However, as cautioned by *Skidmore v. Swift & Co.*, 323 U.S. 134, 65 S.Ct. 161, 164, 89 L.Ed. 124 (1944):

> Deference to an agency's interpretation . . . is not a hard and fast rule. The weight to be given to an administrative interpretation depends upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements,

> and all of those factors which give it power to persuade, if lacking power to control it.

The court in the above case found that a particular rule within an amendment to the Medicaid regulations was not an interpretative rule and thus it would not have been adopted without notice and comment requirements and thus was not legally adopted.

ANALYSIS AND CONCLUSION

Initially, the state was contacted by the Department of Health and Human Services with regard to plan amendment 84-9. The state was advised to evaluate the plan amendment methods and standards in view of the passage of the Deficit Reduction Act of 1984. The state was advised to evaluate its plan to be sure that it "does not result in capital payments that might exceed the new requirements." (Letter to B.F. Simmons from HHS dated August 30, 1984). Supposedly, in an effort to comply with DEFRA, the state submitted 84-36, which revised the state's methodology for the reimbursement of depreciation, interest, and return on equity for long-term care facilities, where there has been a change in ownership.

On December 27, 1984, the HHS, by letter, informed the state, *inter alia*, that "The State has not submitted the assurances and related information required for significant plan amendments as specified at 42 C.F.R. § 447.253." The letter further stated, "the plan amendment should be considered significant and the appropriate assurances specified at 42 C.F.R. § 447.253 should be submitted." The letter informed the state that although the amendment was considered significant, "the effective

date of the plan provision will not be affected, since the plan provision is a technical amendment bringing the State plan into compliance with a statutory change."[3] On February 26, 1985, the state forwarded to HCFA additional information with reference to transmittal 84-36 which included the following assurance:

> 6.(a) Public notice is not required as the change is to bring the State in compliance as a result of statutory change.

Confusingly, the letter also supposedly submitted a copy of the public notice that would have been required. Paragraph (h) of the letter stated: "A copy of the public notice is enclosed."

A plan was approved by HCFA. In a HCFA memorandum dated April 10, 1985, from the Division of Alternative Reimbursement Systems to the Division of Financial Operations, reference was made to an earlier memorandum of December 1984 wherein the agency considered the proposed amendment "to be a significant change in the State of Mississippi's methods and standards for establishing payment rates requiring submission of the assurances and related information specified at 42 C.F.R. § 447.250-256." In listing the assurances provided by the state, the notice requirement was not mentioned. The federal agency further stated, "Since these provisions are, in effect, more restrictive than Medicare

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[3] The state also received a similar letter with regard to transmittal 84-9 in that it was informed by HHS that it has not submitted the assurance with regard to notice as required under the federal regulations.

rules with regard to reevaluation of assets, we recommend acceptance of the State's assurance."

The defendant, during oral argument on this matter, admitted that the State's plan is more restrictive than the requirements set forth under DEFRA. However, the defendant argues that the plan falls within the notice exception because the changes that were made in the depreciation allowance and recapture provisions when considered "in the aggregate" with interest on capital and return on equity factors conform to Medicare methods and levels of reimbursement.

The court is unpersuaded by the defendant's argument. Clearly, the federal agency as well as the state have noted that the plan amendment in question is more restrictive than the requirements under DEFRA and further that the amendment constituted a significant change requiring strict compliance with the federal regulations. Further, Bernard J. Truffer, employed by HCFA and charged with review and analysis of amendments to state medicaid plans, testified through affidavit that although he did not believe that notice was required, that subsequent to the approval of 84-36 he revised his opinion "as to whether the Mississippi plan in fact complied with the DEFRA requirements." Upon review of information from the state Medicaid agency to show that the plan did meet DEFRA requirements, Mr. Truffer noted that "the plan appeared to permit Medicaid payment increases following a change in ownership in excess of the Medicare standard." This Truffer attributed to the accounting procedures utilized by the state "which differ from the Medicare rules and which affect the state's compliance with the requirement . . . for virtually each facility which

changed ownership in the State, the equity payments under the state's system were higher than that permitted under the Medicare rules."

In some instances, the courts have been willing to excuse full compliance with the notice requirements. *See generally, Seniors United for Action v. Ray,* 529 F. Supp. 55 (N.D. Iowa 1981), aff'd, 675 F.2d 186 (8th Cir. 1982) (where any harm that accompanied a failure to comply with the regulation was remedied by the giving of subsequent notice); *California Association of Bioanalysts v. Rank,* 577 F. Supp. 1342 (C.D. Cal. 1983) (no notice required where changes are mandated by the Legislature, and the changes had already gone through a public process satisfying the objective of the notice requirement). However, where there is a failure to follow the regulatory procedures in enacting certain legislation, the same is rendered void. *See Wisconsin Hospital Association v. Reivitz,* 630 F. Supp. 1015 (E.D. Wis. 1986), aff'd in part, vacated in part on other grounds, 820 F.2d 863 (7th Cir. 1987).

The court finds that the defendant was required to provide public notice of transmittal 84-36. The defendant has failed to convince this court that notice was not required under the facts of this case. It was recognized by the federal agency approving the plan that the amendment constituted a "significant change." The plan itself is recognized by all parties involved as being more restrictive than DEFRA and, thus, clearly was not in compliance with that Act but was beyond what the Act provided for. The purpose of the notice requirement is to assure public awareness of the proposed change and to allow the interested parties an opportunity to comment on the change whether it be in support or in opposition to the proposal.

This the plaintiffs did not have an opportunity to do, and thus the court finds that transmittal 84-36 which altered the method by which DOM computed reevaluation of assets and recapture of depreciation constituted a significant change requiring public notice pursuant to 42 C.F.R. § 447.205. Accordingly, the court finds that transmittal 84-36 is void and of no effect for failure of the defendant to promulgate said amendment in compliance with federal law.

SO ORDERED this the 2nd day of March, 1990.

/s/ Henry T. Wingate
UNITED STATES DISTRICT JUDGE

Civil Action Nos. J89-0731(W)
and J86-0765(W)
Memorandum Opinion and Order

APPENDIX D

42 U.S.C. § 1395x(v)(1)(O) (Supp. 1991), as amended:

(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital or skilled nursing facility which has undergone a change of ownership, such regulations shall provide, except as provided in clause (iv), that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of the date of the enactment of this subparagraph [enacted July 18, 1984] (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

(ii) Such regulations shall provide for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984.

(iii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this title [42 USCS §§ 1395 et seq.].

(iv) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital

allowances to the new owner shall be the book value of the hospital to the state at the time of the transfer.

APPENDIX E

42 C.F.R. § 447.205:

(a) When notice is required. Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

(b) When notice is not required. Notice is not required if –

(1) The change is being made to conform to Medicare methods or levels of reimbursement;

(2) The change is required by court order; or

(3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

(c) Content of notice. The notice must –

(1) Describe the proposed change in methods and standards;

(2) Give an estimate of an expected increase or decrease in annual aggregate expenditures;

(3) Explain why the agency is changing its methods and standards;

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; and

(6) If there are public hearings, give the location, date and time for hearings or tell how this information may be obtained.

(d) Publication of notices. The notice must –

(1) Be published before the proposed effective date of the change; and

(2) Appear as a public announcement in one of the following publications:

(i) A State register similar to the *Federal Register.*

(ii) The newspaper of widest circulation in each city with a population of 50,000 or more.

(iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

APPENDIX F

42 C.F.R. § 447.253, as amended:

(a) State assurances. In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) Payment rates. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services –

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(B) If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level

of care such as skilled nursing or intermediate care services) under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act; and

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(iii) With respect to nursing facility services –

(A) Except for preadmission screening for individuals with mental illness and mental retardation under § 483.20(f) of this Chapter, the methods and standards used to determine payment rates take into account the costs of complying with the requirements of Part 483 Subpart B of this Chapter;

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in § 483.30(c) of this Chapter to provide licensed nurses on a 24-hour basis;

(C) The State establishes procedures under which the data and methodology used in establishing payment rates are made available to the public.

(2) Upper payment limits. The agency's proposed payment rate will not exceed the upper payment limits as specified in § 447.272.

(c) Provider appeals. The Medicaid agency must provide an appeal or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(d) Uniform cost reporting. The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(e) Audit requirements. The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(f) Public notice. The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(g) Rates paid. The Medicaid agency must pay for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.

APPENDIX G

[Pertinent Provisions of Transmittal 84-9]

(3) The assets shall be recorded at cost except as provided by (8) below; however, donated assets shall be recorded at fair market value at the time received based on the lesser of at least two bonafide appraisals. Cost during the construction of an asset, such as architectural, consulting and legal fees, interest, fund raising, etc., should be capitalized as a part of the cost of the asset. When an asset is acquired by a trade-in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt as consideration paid.

(4) Facilities that previously did not maintain fixed asset records and did not record depreciation in prior years will be entitled to any straight-line depreciation of the remaining useful life of the asset. The depreciation shall be based on the cost of the asset or fair market value of a donated asset at the time of purchase, construction or donation, except as provided by (8) below over its normal useful life. No depreciation may be taken on an asset that would have been fully depreciated if it had been properly recorded at the time of acquisition.

(5) Depreciation on facilities that have no fixed asset records and are sold will be recognized to the extent to which the prior owner would have been entitled to depreciation.

(6) Leasehold improvements may be depreciated over the lesser of the asset's useful life or the remaining life of the lease.

(7) Losses realized from the disposal or transfer of depreciable assets, not to exceed 10% of the total allowable depreciation for the year, are an allowable cost. Gains realized from the disposal or transfer of depreciable assets are revenue adjustments to be deducted from allowable depreciation costs.

(8) Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. The change of ownership must be an arm's length transaction consummated in the open market between nonrelated parties in a normal buyer – seller relationship. In a case in which a change in ownership of a provider's depreciable assets occurs, and if a bona fide sale is established, the basis for depreciation will be the lower of:

a) the portion of the purchase price properly allocable to a depreciable asset; or

b) the fair market value of the depreciable asset determined by an independent appraiser who is a member of the American Institute of Real Estate Appraisers or a Senior member of the Society of Real Estate Appraisers; or

c) the asset's historical depreciable basis prior to the sale plus a portion of the difference between that base and the current fair market value of the facility as determined by an independent appraiser. The proportion of the difference between the seller's basis will vary directly with the length of time that the seller maintained continuous ownership of the facility. If

the facility is sold within 48 months or less of ownership, unless approved by the Commission as a hardship case, there will be no step-up in the depreciable basis of the assets, and buyer's basis will be limited to the historical depreciable basis prior to the sale. For each month of the seller's ownership subsequent to 48 months, the depreciable basis for the buyer will be increased by 1.6667 percent of the difference between the historical depreciable basis prior to the sale and the lower of the portion of the purchase price properly allocable to the depreciable asset or the current fair market value of the asset as determined in (b) above. If the basis of a provider's depreciable assets is limited to the historical depreciable basis prior to the sale or a pro rata share as determined above, the estimated useful life of the assets as used by the seller must be used by the buyer.

Example 1: An owner's facility has a historical depreciable basis of $2,000,000. The owner sells the facility after seven years of continuous ownership. An independent appraiser values the facility at $3,500,000 at the time of the sale. The new depreciable basis of the facility is calculated as: $2,000,000 + [($3,500,000 - $2,000,000) X (36 mos. X .016667)] = $2,900,018.

Example 2: Historical depreciable basis of a facility is $2,000,000. Seller has owned facility continuously for 8 years and 4 months. Independent appraised value and the sales price of facility is $6,000,000. The new depreciable basis is calculated as: $2,000,000 + [($6,000,000 - $2,000,000) X (52 mos. X .016667)] = $5,466,736.

Example 3: An owner's facility has a historical depreciable basis of $2,000,000. On June 1, 1984, the provider puts into service additional beds with a historical depreciable basis of $1,000,000. Five years later, the provider sells his facility for $4,750,000 after 7 years of continuous ownership. An independent appraiser values the original portion of the facility at $3,500,000 at the time of sale and values the new addition at $1,250,000. The new depreciable basis of the facility is calculated as follows:

Older portion of facility:	
$2,000,000 + [($3,500,000 - 2,000,000) X	
(36 mos. X .016667)] =	$2,900,018
Newer Addition:	
$1,000,000 + [(1,250,000 - 1,000,000) X	
(12 mos. X .016667)] =	$1,050,001
Total depreciable basis	$3,950,019

(9) Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation (a gain on sale) calculated in accordance with Medicare (Title XVIII) principles of Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture will be determined as follows:

a) The gross recapture amount will be the lesser of the actual gain on the sale or the accumulated depreciation after effective date of January 1, 1984. The gross recapture will be

reduced by 1.6667 percent for each month in excess of 48 months' participation in the Medicaid program. Additional beds and other related depreciable assets put into service will be subject to the same 9 year depreciation recapture phaseout schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds will be reduced by 1.6667 percent for each month in excess of 48 months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets will be allocated to the older and new portions of a facility as follows. For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sales price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sale Price: $6,000,000

Older Portion of facility:

Number of beds = 60

Newer portion of facility:

Number of beds = 120

Allocation to older portion: (60/180) X 6,000,000 =	$2,000,000
Allocation to new portion: (120/180) X 6,000,000 =	$4,000,000
Sale Price	$6,000,000

b) The adjusted gross recapture amounts as determined in (a) above shall be allocated for fiscal periods from Jan 1, 1984, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs will be recomputed for each period after depreciation recapture. The recomputed allowable costs will be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment will be recovered.

c) The net recapture overpayment amount, if any, so determined in (b) above will be paid by the former owner(s) to the Medicaid Commission. If the net recapture amount is not paid by the former owner, in total or part, the amount not paid will be deducted from the future payments by the Mississippi Medicaid Commission to the buyer until net recapture has been received. When a proposed buyer notifies the designated planning agency of its intent to change ownership, the designated planning agency is required to notify the proposed buyer of the possibility of this obligation. Such recapture from the buyer shall not increase the buyer's basis in the depreciable assets and shall not be depreciated over the remaining useful lives of the assets. Mississippi Medicaid Commission reserves the right to grant exceptions or terms of extended payment based upon the facts and circumstances of the unrecovered recapture from the seller.

(10) Depreciation recapture resulting from leasing facility or withdrawing from the Medicaid Program. In

cases where an owner-operator withdraws from the Medicaid Program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the time he was the Medicaid provider will be subject to the depreciation recapture provision of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as the licensed Medicaid provider. On or after January 1, 1984, all owner-providers who withdraw from the Medicaid Program will be required to sign a contract with the Commission creating an equitable lien on the owner's nursing home assets. The contract will specify the method for computing depreciation recapture, in accordance with the provisions of this plan, and the contract will state that such recapture so determined will be due to the Mississippi Medicaid Commission upon sale of the facility. In the event that an owner-provider withdraws from the Medicaid Program, the reduction in the gross depreciation recapture amount calculated in Section 3-1 B. (4) i (9) A above shall be computed using only the number of consecutive months that the facility is used to serve Medicaid recipients.

(11) As a basis for allowing depreciation on capital building construction or renovation costs exceeding $100,000 prior approval of the State Health Planning and Development Agency must be secured to meet the requirements of Section 1122 of the Federal Social Security Act. If the prior approval is not obtained, no depreciation cost will be allowed for expenditures for such capital building construction or renovation, unless such

approval is subsequently received, although operational costs will be considered as a regular expense.

(12) Where purchase of a facility or improvements thereto are financed by tax-exempt bonds, the acquired property, plant or equipment must be capitalized and depreciated over the life of the asset. The depreciation and not the installment payment is considered an allowable cost. The amortization of interest in accordance with the terms of the bond issue is an allowable cost. Where the principal amount of the bond issue was expended in whole or part on capital assets which fail to meet the requirements above regarding eligibility for depreciation, the includable depreciation shall be proportionately reduced.

(13) The fixed asset records shall include: the depreciation method, a description, the date acquired, cost, salvage value, depreciable cost, estimated useful life, depreciation for the year, and accumulated depreciation.

(14) Funding is required for depreciation allowed for future replacement of assets obtained through Federal or State funds or grants; e.g., legacy foundation grants, Hill-Burton grants, etc. Funding of other depreciation is recommended in order that funds will be available for future replacement of assets by the facility.

3-4 Interest Expense

(a) Interest charges, finance charges and other costs related to property acquisition and interest and other related cost on current and capital indebtedness are allowable costs except as provided by (g) below.

(b) Loans which result in excess funds or investments are not allowable costs.

(c) Interest applying mortgages on the property and plant of the facility will be included in allowable costs except as provided by (g) below.

(d) Interest incurred on a loan made for a purpose reasonably related to patient care will be included in allowable costs except as provided by (g) below.

(e) Interest incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made will be recognized. In no case will allowable costs for interest exceed limitation set by State Law.

(f) Interest income earned on funded depreciation money is not offset against allowable interest expense.

(g) Where interest expense is incurred to finance the purchase of a long term care facility or a depreciable asset used therein and the purchase price exceeds the allowable cost basis as stated in section 3-1 B. 4i (8), interest expense on that portion of the debt or other interest bearing instrument used to finance the excess of the purchase price over the allowable cost basis is not

considered reasonably related to patient care and is not allowable.

Example:

Sale Price	$6,000,000	
Allowable Cost Basis	4,000,000	
Unallowable	$2,000,000	
Amount of Sale Price Financed		$3,000,000
Ratio of Allow Cost Basis/Sell Price		2/3

Interest expense considered reasonably related to the financing of assets used for patient care would be limited to interest on $2,000,000 ($3,000,000 x 2/3).

APPENDIX H

[Pertinent Provisions of Transmittal 84-36]

(3) The assets shall be recorded at cost except as provided by (8) below; however, donated assets shall be recorded at fair market value at the time received based on the lesser of at least two bonafide appraisals. Cost during the construction of an asset, such as architectural, consulting and legal fees, interest, fund raising, etc., should be capitalized as a part of the cost of the asset. When an asset is acquired by a trade-in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt as consideration paid.

(4) Facilities that previously did not maintain fixed asset records and did not record depreciation in prior years will be entitled to any straight-line depreciation of the remaining useful life of the asset. The depreciation shall be based on the cost of the asset or fair market value of a donated asset at the time of purchase, construction or donation, except as provided by (8) below over its normal useful life. No depreciation may be taken on an asset that would have been fully depreciated if it had been properly recorded at the time of acquisition.

(5) Depreciation on facilities that have no fixed asset records and are sold will be recognized to the extent to which the prior owner would have been entitled to depreciation.

(6) Leasehold improvements may be depreciated over the lesser of the asset's useful life or the remaining life of the lease.

(7) Losses realized from the disposal or transfer of depreciable assets, not to exceed 10% of the total allowable depreciation for the year, are an allowable cost. Gains realized from the disposal or transfer of depreciable assets are revenue adjustments to be deducted from allowable depreciation costs.

(8) Change in ownership of capital assets.

For purposes of this plan, a change in ownership of assets includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer – seller relationship. In a case in which a change in ownership of a provider's depreciable assets occurs, and if a bona fide sale is established, the evaluation of the asset shall be the lessor of:

a) the allowable acquisition cost of such asset to the first owner of record on or after July 18, 1984; or

b) the acquisition cost of such asset to the new owner.

Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset whether by acquisition or merger for which any payment has previously been made shall not be considered reasonable in the provision of health care services and therefore shall not be included in allowable costs. These costs include,

but are not limited to, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

The depreciation expense on assets involved in a change of ownership that may be included in allowable costs on or after October 1, 1984, may not exceed the depreciation expense of the previous owner of record as of July 18, 1984.

(9) Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation (a gain on sale) calculated in accordance with Medicare (Title XVIII) principles of Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture will be determined as follows:

a) The gross recapture amount will be the lesser of the actual gain on the sale or the accumulated depreciation after effective date of October 1, 1984.

b) The gross recapture amounts as determined in (a) above shall be allocated for each fiscal period. The gross depreciation recapture will be adjusted based on the percentage of Medicaid utilization, and any resulting overpayment will be recovered.

c) The net recapture overpayment amount, if any, so determined in (b) above will be paid by the former owner(s) to the Division of Medicaid. If the net recapture amount is not paid by the former owner, in total or part, the amount

not paid will be deducted from the future payments by the Division of Medicaid to the buyer until net recapture has been received. When a proposed buyer notifies the designated planning agency of its intent to change ownership, the designated planning agency is required to notify the proposed buyer of the possibility of this obligation. Such recapture from the buyer shall not increase the buyer's basis in the depreciable assets and shall not be depreciated over the remaining useful lives of the assets. The Division of Medicaid reserves the right to grant terms of extended payment based up the facts and circumstances of the unrecovered recapture from the seller.

(10) Depreciation recapture resulting from leasing facility or withdrawing from the Medicaid Program.

In cases where an owner-operator withdraws from the Medicaid Program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the time he was the Medicaid provider will be subject to the depreciation recapture provision of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as the licensed Medicaid provider. On or after January 1, 1984, all owner-providers who withdraw from the Medicaid Program will be required to sign a contract with the Commission creating an equitable lien on the owner's nursing home assets. The contract will specify the method for computing depreciation recapture, in accordance with the provisions of this plan, and the contract will state that such recapture so determined will be due to the Division of Medicaid upon sale of the facility.

In the event that an owner-provider withdraws from the calculated in Section 3-1 B (4) i (9) A above shall be computed using only the number of consecutive months that the facility is used to serve Medicaid recipients.

(11) As a basis for allowing depreciation on capital building construction or renovation costs exceeding $100,000 prior approval of the State Health Planning and Development Agency must be sucured [sic] to meet the requirements of Section 1122 of the Federal Social Security Act. If the prior approval is not obtained, no depreciation cost will be allowed for such capital building construction or renovation, unless such approval is subsequently received, although operational costs will be considered as a regular expense.

(12) Where purchase of a facility or improvements thereto are financed by tax-exempt bonds, the acquired property, plant or equipment must be capitalized and depreciated over the life of the asset. The depreciation and not the installment payment is considered an allowable cost. The amortization of interest in accordance with the terms of the bond issue is an allowable cost. Where the principal amount of the bond issue was expended in whole or part on capital assets which fail to meet the requirements above regarding eligibility for depreciation, the includable depreciation shall be proportionately reduced.

(13) The fixed asset records shall include: the depreciation method, a description, the date acquired, cost, salvage value, depreciable cost, estimated useful life, depreciation for the year, and accumulated depreciation.

(14) Funding is required for depreciation allowed for future replacement of assets obtained through Federal or State funds or grants; e.g., legacy foundation grants, Hill-Burton grants, etc. Funding of other depreciation is recommended in order that funds will be available for future replacement of assets by the facility.

3-4 Interest Expense

(a) Interest charges, finance charges and other costs related to property acquisition and interest and other related cost on current and capital indebtedness are allowable costs except as provided by (g) below.

(b) Loans which result in excess funds or investments are not allowable costs.

(c) Interest applying mortgages on the property and plant of the facility will be included in allowable costs except as provided by (g) below.

(d) Interest incurred on a loan made for a purpose reasonably related to patient care will be included in allowable costs except as provided by (g) below.

(e) Interest incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made will be recognized. In no case will allowable costs for interest exceed limitation set by State Law.

(f) Interest income earned on funded depreciation money is not offset against allowable interest expense.

(g) Where interest expense is incurred to finance the purchase of a long term care facility or a depreciable asset

used therein and the purchase price exceeds the allowable costs basis as stated in section 3-1 B. 4i (8), interest expense on that portion of the debt or other interest bearing instrument used to finance the excess of the purchase price over the balance of the indebtedness by the previous owner at the time of the sale is not considered reasonably related to patient care and is not allowable.

The interest rate incurred may not exceed the rate of the indebtedness on the asset by the previous owner at the time of the sale. If the owner of an existing facility or depreciable asset refinances the indebtedness on the facility or depreciable asset, any interest on the amount financed in excess of the original indebtedness or the original interest rate is not allowable.

Appendix J

Return on Equity Capital of Proprietary Providers. For the purpose of this subpart, the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a non-profit basis.

For purposes of computing the allowable return, the provider's equity capital means:

> The provider's investment in plant, property and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds), and net working capital maintained for necessary and proper operation of patient care activities.

Notwithstanding the above debt representing loans from partners, stockholders, or related organizations on which interest payments would be allowable as costs but for the provisions stated under allowable interest expense, is includable in computing the amount of equity capital in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the value determined in Section 3-1, B, 4, i, (8).

Computation of Return on Equity Control. For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

Unapproved Capital Expenditures. With respect to any capital expenditure, a provider's investment in plant, property, and equipment related to patient care, and funds deposited by a provider which leases plant, property, or equipment related to patient care which are found to be expenditures which have not been submitted to the

designated planning agency, as required or have been determined to be inconsistent with health facility planning requirements, are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

Exclusion from Computation of Average Equity Capital. For the purpose of computing average equity capital, the following are examples of items not to be included in the computation:

Notes and loans receivable from owners or related organizations.

Goodwill.

Unpaid capital surplus.

Treasury stock.

Unrealized capital appreciation surplus.

Cash surrender value of life insurance policies.

Prepaid premiums on life insurance policies.

Assets acquired in anticipation of expansion and not presently used in the provider's operation or in the maintenance of patient care activities during the rate period.

Inter-company accounts.

The value of any motor vehicle that is attributed to personal use.

Any other assets not directly related to or necessary for the provision of patient care to publicly-aided patients.

Funded Depreciation.

Non-allowable cost of capital assets as specified in Section 3-1, B, 4, i, (8).

APPENDIX I

[Logo]
DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

December 27, 1984

Refer to:
DFO/RR/DE

Mr. B. F. Simmons, Director
Office of the Governor
Division of Medicaid
Post Office Box 16786
Jackson, Mississippi 39236

Dear Mr. Simmons:

Re: Mississippi Reimbursement Plan for Long-Term Care Facility Services – Transmittal Number 84-36 – Additional Information

This is in response to your proposal to amend your reimbursement plan for long-term care facility services. The plan amendment, transmittal 84-36, effective October 1, 1984, revises the State's methodology for the reimbursement of depreciation, interest, and return on equity for long-term care facilities, where there has been a change in ownership.

Our review of the plan amendment was conducted in accordance with the statutory requiements speciifed at 1902(a)(13)(A) and 1902(a)(13)(B) of the Social Security Act. Based on our review, we have the following comments:

1. The statute at 1902(a)(13)(B) states that a State must provide an assurance that the State's payment methodology can reasonably be expected not to increase payments in excess of the increase which would result from application of the Medicare provision at 1861(v)(1)(O). The State has not as yet submitted the required assurance. The State should be advised to submit the assurance and demonstrate generally how the assurance is met. In making the assurance the State must consider Medicare provisions for depreciation, interest capital indebtedness, return on equity, recapture of depreciation, and acquisition costs for which payments under the program were previously made to the original owner.

2. The statute limits the *increase* in Medicaid payments, resulting from a change in ownership, to the *increase* which is allowable under Medicare. Under Medicare, where there has been a change in ownership, the revaluation of the assets is limited to the lesser of the acquisition costs to the owner of record on or after July 18, 1984, or the purchase price to the new owner. The State should be advised that although it may adopt the Medicare provision as specified at section 1861(v)(1)(O), the Medicaid statute only mandates a limit on the *increase* in the amount a State is allowed to pay for specified capital costs as a result of a change in ownership. The Medicaid statute does not require that the Medicare provisions be adopted by each State and does not mandate a specific methodology that must be used for the revaluation of assets.

The Medicaid provision at 1902(a)(13)(B) does *not* restrict reimbursement for capital, under Medicaid, to the lesser of the cost under *Medicaid* to the owner of record on enactment or the purchase price and it does not *eliminate* upward revaluation. States are free to adopt changes to their State plans that would revise the methodology for the reimbursement of capital costs. The specific methodology used by a State prior to July 18, 1984 is not the controlling factor.

3. The State has specified that the revaluation of the asset shall not exceed the allowable costs of the asset to the first owner of record on or after October 1, 1984. The new provision applies to payment for services rendered on or after October 1, 1984, and is applied using the costs of the owner of record on or after *July 18, 1984*.

4. The plan amendment, on page 38a, cites a January 1, 1984, date. However, since that date is 9 monts [sic] prior to the effective date of the plan amendment, it appears that this date may be incorrect. In addition, the last sentence of that paragraph seems to be incomplete.

5. The plan amendment limits the amount of interest expense that will be allowed where there has been a change in ownership. In the State's example, the State has shown that it would allow interest on a proportion of the allowable cost basis as related to the sale price of the asset. However, we believe that this methodology may result in an increase which exceeds the amount Medicare would allow where there has been a change of

ownership. Under Medicare (using the figures in the State's example) interest expense would only be allow on the amount in excess of the nonfinanced portion ($3 million) up to the allowable cost basis ($4 million). Therefore, interest on only $1 million would be allowed.

6. The State has not submitted the assurances and related information required for significant plan amendments as specified at 42 CFR 447.253. However, due to the fact that the amendment could apply to all providers and the extensive provider interest in this matter, the plan amendment should be considered significant and the appropriate assurances specified at 42 CFR 447.253 should be submitted. Although the plan amendment should be considered significant, the effective date of the plan provision will not be affected, since the plan provision is a technical amendment bringing the State plan into compliance with a statutory change.

We are suspending further review pending receipt of your assurances and other clarifying information. If you have any questions, please call me or Dick Edwards at 404-221-2742.

Sincerely,

/s/ James J. Pirkle
James J. Pirkle
Associate Regional Administrator
Division of Financial Operations

APPENDIX J

[SEAL]

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

BILL ALLAIN
Governor

B. F. SIMMONS
Director

February 26, 1985

Mr. James J. Pirkle
Associate Regional Administrator
Division of Financial Operations
Health Care Financing Administration,
Region IV
Post Office Box 1715
Atlanta, Georgia 30301

Re: DFO/RR/DE
Mississippi Reimbursement Plan for Long-Term Care
Facility Services – Transmittal Number 84-36

Dear Mr. Pirkle:

This is in response to your request for additional information for Transmittal Number 84-36. We have revised our Transmittal Number 84-36 and submit it for your approval with the following responses to your request for additional information.

1. The State assures that the payment methodology can reasonably be expected not to increase payments for depreciation, interest and return on equity upon the revaluation of assets due to a change of ownership. Our plan amendment 84-36 does not allow an increase in the basis used for depreciation or return on equity of the previous owner and

it does not allow an increase in the amount financed or the interest rate.

2. It is our intent that our plan does not allow upward revaluation of assets in accordance with our interpretation of Section 2314 of the Deficit Reduction Act of 1984.

3. We have amended our Transmittal Number 84-36 to use the costs of the owner of record on or after July 18, 1984.

4. Page 38a of our plan amendment includes a January 1, 1984 date. This is a date that was in our plan amendment 84-9 which you previously approved.

5. We have amended our Transmittal 84-36 in order to limit interest expense allowable to that of the previous owner. The new owner may only include in allowable costs the interest on the balance of the previous owner's indebtedness at the time of the sale and the interest rate may not exceed that of the previous owner.

6. The State submits the following assurances and related information required for significant plan amendments as specified at 42 CFR 447.253.

   (a) Public notice is not required as the change is to bring the State in compliance as a result of statutory change.

   (b) The State reimburses long-term care facilities through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in

conformity with applicable State and Federal laws, regulations and quality of care.

(c) The average per diem rates for the fiscal years ended June 30, 1985 and 1984 are as follows:

Classification	FY 1985	FY 1984	Increase (Decrease)
SNF	$37.06	$37.51	$ (.45)
ICF	$29.10	$29.46	$ (.36)
ICF/MR	$46.12	$46.14	$ (.02)
Small Dual	$33.56	$33.69	$ (.13)
Mid Dual	$31.85	$32.14	$ (.29)
Large Dual	$32.10	$31.80	$ .30

(d) The approval of the proposed plan change is estimated to have no significant short-term or long-term effect on the availability of services, the type of care furnished or provider participation.

(e) The plan provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and request prompt administrative review of payment rates.

(f) The plan provides for the filing of uniform cost reports by each participating provider.

(g) The plan provides for periodic audits of the financial and statistical records of participating providers.

(h) A copy of the public notice is enclosed.

(i) The Division of Medicaid has set upper limits on per diem rates of the lesser of the 60th percentile determined by classification in accordance with the State Plan, the amount of a provider's customary charges to the general public or the amount that would be paid for the services under the Medicare principals of reimbursement.

(j) Rates paid are determined in accordance with an approved State Plan.

Should you have any additional questions, please contact Mrs. Jamie Collier of this office at 981-4507, extension 123.

Sincerely,

/s/ B. F. Simmons
B. F. Simmons
Director

BFS/JLC/mb

Enclosure

cc: Mrs. Melba Smith, DOM
Mrs. Jamie Collier, DOM

NOTE: Only the revised pages of Transmittal 84-36 have been submitted with this letter. Please substitute them in your six copies of Transmittal 84-36.

APPENDIX K

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

(seal)

APR 10, 1985 **Memorandum**

Date

From Director
Division of Alternative Reimbursement Systems

Subject Mississippi Reimbursement Plan for Long-Term Care Facility Services, Transmittal 84-36 (Your memorandum of March 5, 1985) – ACTION

To Associate Regional Administrator
Division of Financial Operations
Region IV

This is in further response to the State of Mississippi's proposal to amend its reimbursement plan for long-term care facility services. The plan amendment, transmittal 84-36, effective October 1, 1984, revises the State's methodology for the reimbursement of depreciation, interest, and return on equity for long-term care, in situations in which there has been a change of ownership.

Our memorandum dated December 13, 1984, indicated that we considered the proposed amendment to be a significant change in the State of Mississippi's methods and standards for establishing payment rates requiring submission of the assurances and related information specified at 42 CFR 447.250-256. We also

requested submission of the assurance required by section 1902(a)(13(B) of the Social Security Act. The State of Mississippi's letter contained the following responses to these requests:

Assurances and Findings

The State has provided the following assurances:

- o Findings (42 CFR 447.253(b))
- o Reasonable and adequate payment rates (42 CFR 447.253(b)(1)(i))
- o Upper limit (42 CFR 447.253(b)(2))
- o Provider appeals (42 CFR 447.253(c))
- o Uniform cost reporting and periodic audits (42 CFR 447.253(d) and (e))
- o Rates paid (42 CFR 447.253(g))

Related Information

The State was complied with the requirements for the submission of the related information described at 42 CFR 447.255 of the regulations. The State submitted the proposed average payment rates and the amount of increase or decrease over the immediately preceding rate period listed below:

	Proposed Rate	Previous Rate	Changes
SNF	$37.06	$37.51	$ (.45)
ICF	$29.10	$29.46	$ (.36)
ICF/MR	$46.12	$46.14	$ (.02)
Small Dual	$33.56	$33.69	$ (.13)
Mid Dual	$31.85	$32.14	$ (.29)
Large Dual	$32.10	$31.80	$ .30

The State also indicates that the proposed amendment is not expected to have significant short or long-term effects on the availability of service, the type of care furnished or the extent of provider participation.

Our memorandum of December 13, 1984, called to the attention of the State an incomplete sentence in paragraph 10 on page 38(c) of attachment 4.19-D. While the plan material involved is not related to the proposed amendment, we recommend that, since they did not comment, the regional office again advise the State of this problem.

Revaluation of Assets

Our memorandum of December 13, 1984, called to the attention of the State that its proposed amendment specified that the revaluation of assets shall not exceed the allowable cost of the asset to the first owner of record on or after October 1, 1984. We pointed out that the relevant provision applies to payments for services rendered on or after October 1, 1984, to costs of the owner of record on or after July 18, 1984. The State submitted a proposed further amendment of page 37 of attachment 4.19-D to reflect this change. Our memorandum of December 13, 1984, also questioned whether the methodology contained in the proposed amendment for limiting interest expenses allowed where there has been a change in ownership would result in an increase exceeding the amount Medicare would allow where there has been an ownership change. In response, the State submitted a revision to page 38c of attachment 4.19-D which limits interest expenses allowable to that of the previous owner. The new owner may only

include as an allowable cost interest on the balance of the previous owner's indebtedness at the time of the sale. The interest rate may not exceed that of the previous owner.

DEFRA 2314 Assurance

The State of Mississippi has submitted the assurance required by section 1902(a)(13)(B) of the Social Security Act that its payment methodology can reasonably be expected not to increase payments in excess of the Medicare provisions at 1861(v)(1)(O). We note that the State indicates in support of its assurance that its plan does not allow for the upward revaluation of assets. Specifically, the proposed amendment does not allow an increase in the amount financed, the interest rate or the basis used for depreciation or return on equity. Since these provisions are, in effect, more restrictive than Medicare rules with regard to revaluation of assets, we recommend acceptance of the State's assurance.

In view of the State's submission of the assurances and related information required by section 1902(c)(13)(A) and (B) of the Social Security Act, and its satisfactory response to the concerns expressed in our memorandum of December 13, 1984, we recommend that the regional office approve the plan amendment.

Questions concerning this plan amendment should be directed to Tom Fulda at FTS 987-1805.

/s/ Anthony C. Lovecchio
Anthony C. Lovecchio

cc: Regional Administrator

APPENDIX L

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

(seal)

6325 Security Boulevard
Baltimore, MD 21207

DEC 23 1988

Mr. William Phillips
Division of Medicaid
State of Mississippi
Suite 801
Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201-1311

Dear Mr. Phillips:

This is in response to your letter of November 30, 1988, concerning the State of Mississippi's amendment, TN 84-36 to its plan for Medicaid payment of long-term care facility services. This amendment, which was effective October 1, 1984, concerns procedures to be used by the State for payment for capital costs following a change in ownership and was submitted by the State in response to the requirements of Section 2314 of the Deficit Reduction Act of 1984 (P.L. 98-369). We understand that the amendment is presently the subject of litigation in the Federal Courts.

Your letter requested that we provide you with additional information concerning our opinion, expressed in our memorandum dated April 10, 1985, to the Health Care financing Administration's regional office in Atlanta

concerning this amendment, that we believed the State's procedures for revaluation of assets following a change in ownership were more restrictive than those permitted under the Medicare Principles of Reimbursement at section 1861(v)(1)(O) of the Social Security Act. To this end, your letter enclosed material prepared by State staff and by an independent accounting firm which is intended to demonstrate the differences in the two sets of procedures.

By way of explanation of our earlier opinion, it might be appropriate to discuss the statutory requirements of section 2314 and the procedures for revaluation permitted under the State's amendment. Section 2314 of the DEFRA amended section 1902(a)(13)(B) of the Social Security Act to require that, effective October 1, 1988, each States would be required to provide to the Secretary an acceptable assurance that its Medicaid plan did not permit increases in payments for capital costs, due solely to a change in ownership, to exceed that permitted under the Medicare rules at section 1861(v)(1)(O) of the Act. This section in turn, requires that, for purposes of Medicare reimbursement, following a change in the ownership of a facility after July 17, 1984, the valuation of the asset to the new owner may not exceed that permitted to the owner of record on that date. Stated another way, the basis for determining payments to the buyer for depreciation, interest and return on equity capital on a capital asset may not exceed the equation cost of the seller. It is important to note that the statute's requirements do not directly address the depreciation, interest and equity return payments themselves, but are directed to limiting a change in the base value of the capital asset.

Section 1902(a)(13)(B) of the Act, in providing for the companion requirement for Medicaid, addresses the requirement somewhat differently, considering the flexibility of States to design unique payment methods for hospitals and long-term care facilities. Section 1902(a)(13)(B) requires that increases in payment rates, due solely to a change in ownership, not increase more than would be permitted under the Medicare principle at section 1861(v)(1)(O) of the Act. Consequently, to assess a State's compliance with the statutory provision, it is necessary to consider the *change* in payments to a facility following a change in ownership under both the Medicare principles at section 1861(v)(1)(O) and the State's procedures, as articulated in the State's Medicaid plan.

Under the Medicare principles, it is possible that, even though the asset's base value is not increased due to the change in ownership, payments for depreciation, interest, and return on equity capital could be increased. This could occur, for example, due to the new owner financing the asset at an interest rate higher than that of the seller. Additionally, interest payments could be increased because the new owner is financing a greater proportion of the asset's value than did the seller.

Under the State's amendment TN 84-36, the State of Mississippi provides that, at least for interest and depreciation, *payments* to the new owner may not be increased above those made to the seller (emphasis supplied). With respect to interest costs, the State restricts the buyer to both the interest rate and the amount of the indebtedness of the former owner. This would preclude recognition of

either higher interest rates or financing of a greater balance than the previous owner. With respect to depreciation payments, the State would limit the new owner to the depreciation expense accorded to the owner of record on July 17, 1984. Therefore, if a facility were fully depreciated, the new owner would presumably not be entitled to claim any depreciation expense.

With respect to equity capital, the State follows the Medicare principle in that it limits the basis for determining the amount of equity in a facility to the value of the facility to the seller.

With the above in mind, we concluded, at the time that we reviewed the amendment, that it was more restrictive than the Medicare principles. We based this conclusion primarily on the State's procedures for calculating interest and depreciation payments following a change in ownership. As we read the plan, the buyer's interest expense *may not exceed* that permitted under Medicare and may well be lower, if the buyer's interest rate is higher than that of the seller or if the buyer finances a larger amount than the seller's balance.

However, we have recently been informed by State staff of procedures, not in the plan that may alter the payment provisions somewhat. Under the Medicare principles, if a facility were sold for more than the maximum valuation of the asset for payment purposes, Medicare would limit the sum of the amount of the debt and equity to the new owner to the maximum. It would accomplish this by first crediting the new owner's equity with the amount of his down payment, then by computing the a maximum amount of debt for calculating interest

expense. The State, although not specified in the plan, reverses this process. The result of this difference, coupled with the State's interest limit, is that the State's plan could permit payments to exceed the Medicare standard. This is because the State's plan could permit relatively more equity than would Medicare. Because the rate of return on equity capital is generally higher than the interest rate, it could well be the result that the increase in payments under the State plan due to a change in ownership exceed that permitted under the Medicare principles.

With respect to the rules regarding public notice, it was our policy, at the time TN 84-36 was adjudicated, that any amendment that constituted a significant change in the plan's methods and standards for determining payment rates was considered a "significant amendment" and was required to be accompanied by the assurances and related information required by the Federal regulations at 42 CFR 447.253 and .255. One of the required assurances concerned compliance with the public notice rules at 447. 205. This rule in turn, required publication of a public notice for "any significant proposed change" in the State's methods and standards. While the determination of significance was generally within the realm of discretion accorded to States, that determination was subject to Federal review.

You also asked about the effect of the recapture of depreciation provision in the Medicare rules. It is our policy that recapture must be taken into account in computing the amount of the increase that Medicare principles permit. We understand that the plan requires recapture.

Please feel free to contact me again if you require further information.

Sincerely,

/s/ Bernard J. Truffer
Bernard J. Truffer
Chief, Special
Reimbursement
Program Branch

APPENDIX M

REPORT ON THE

FY 1989

STATE PERFORMANCE EVALUATION AND

COMPREHENSIVE TEST OF REIMBURSEMENT

UNDER MEDICAID

(SPECTRUM)

LEVEL 1 REVIEW

OF

THE STATE OF MISSISSIPPI

ICF/MR FACILITIES

CONDUCTED BY:

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

DIVISION OF MEDICAID

MEDICAID FINANCIAL MANAGEMENT BRANCH

Reviewers: Dick Edwards
Howard Culver

Report Date: July 20, 1989 (Revised)

INTRODUCTION

This report summarizes the FY 1989 SPECTRUM review of the State of Mississippi ICF/MR provider cost reimbursement plan. The review was conducted at the Mississippi Medicaid Commission (MMC) during the month of January 1989. The review was performed on a selective basis and included tests of appropriate records and other controls as deemed necessary.

BACKGROUND

The Health Care Financing Administration (HCFA) has the responsibility to ensure that States are operating their Medicaid (Title XIX) institutional reimbursement systems in a manner that:

1. encourages prudent use of program funds, and

2. provides a reasonable degree of assurance that funds are being expended properly, and for the purposes for which appropriated and provided for under the Social Security Act and State plan, including State laws and regulations.

In order to provide a basis for determining that State agencies are adhering to Federal requirements and to the substantive legal and administrative provision of their approved plans, the HCFA regional offices (RO) conduct a review of the States' administration of their Medicaid institutional reimbursement program.

In FY 1984 the regions used the hospital or LTC institutional reimbursement protocols of the State Assessment Guide for the hospital or LTC Systems Test of Alternative Reimbursement (STAR) programs to evaluate State Medicaid institutional reimbursement performance. This SPECTRUM program consolidates and replaces these protocols and programs.

The SPECTRUM program was developed by first identifying those questions that form the basis of a comprehensive review of a State's Medicaid long-term care (LTC),

ICF/MR or hospital reimbursement actions. The questions identified were organized into the following seven actions: Rate setting, Findings, Cost Reports, Audits, Appeals, All Inclusive Rates, and Financial Accountability.

PROGRAM OBJECTIVES

The major objectives of the SPECTRUM program are to:

1. Provide a nationally uniform evaluation of a State's Medicaid hospital and/or LTC institutional reimbursement actions which includes the following:
   a. the discovery of problems with the application of the State plan; i.e., determining whether the State reimbursed providers in accordance with the State plan and made the required findings, and
   b. the identification of causes of errors and the effectuation of immediate corrective actions including the recovery of any applicable misspent Federal financial participation funds (FFP), and
2. Identify problems with Federal and State Medicaid institutional reimbursement system laws, regulations and instructions and to communicate the problems found to the appropriate party.

SCOPE OF REVIEW

The SPECTRUM program contains two levels of review, i.e., level I and level II. Level I is a basic review and

includes only those questions deemed to be currently required to provide a minimum level of evaluation of a State's Medicaid LTC or hospital reimbursement actions. A level I review was performed in Mississippi. Prior to our visit to the agency, we obtained and reviewed the current approved State plan, State plan amendments, and the appropriate State manuals and regulations which supplement the State plan. We also reviewed copies of prior reviews performed by the Health Care Financing Administration. We discussed our review with the appropriate State agency staff responsible for the administration and payment of ICF/MR providers as well as the contracted Fiscal Agent staff involved in the reimbursement of ICF/MR providers.

FINDINGS AND RECOMMENDATIONS

Finding: Rate Increase Resulting from Changes in Ownership Exceeded State Plan Requirements:

We approved the Mississippi State Plan Amendment, Transmittal No. 84-36, which implemented Section 2314 of the Deficit Reduction Act of 1984 (DEFRA). In our approval, we accepted the State's assurance that Mississippi's payment methodology can reasonably be expected not to increase payments solely as a result of a change of ownership that occurs on or after July 18, 1984, in excess of the increase permitted by the Medicare program.

As a routine part of the SPECTRUM Review we evaluated the cost data maintained by the Mississippi Medicaid Agency supporting this assurance for Nursing Home sales for the period 10/1/84 – 11/4/87. Our review of the Agency's records showed that payments were increased

in excess of the increase permitted by the Medicare program by $222,675, with Federal Financial participation (FFP) of $174,358.

The increase can be attributed to the 15 percent return on equity that is currently being paid to Nursing Home providers as well as the methodology being followed for determining allowable debt and interest expense following changes of ownership of Long Term Care Facilities. Since these procedures are part of the current approved reimbursement plan, they have provided payments that have exceeded the amount that can reasonably be estimated that would have been paid for these services under DEFRA Medicare payment principles.

Recommendation:

The State has paid $222,675 ($174,358 FFP) in excess of the increases permitted by the DEFRA limits which are specified in your approved State plan. The State should return the $174,358 FFP on the next Quarterly Medicaid Statement of Expenditures (Form HCFA-64) report.

State's Response:

The State concurs with our finding but contends that the cause was not only the higher return on equity rate but also the methodology used to determine allowable debt and allowable interest following the sales of Long Term Care Facilities.

R.O. Comments:

The R.O. agrees with the State's contention and has reworded the finding to reflect all of the causes of the overpayment.

Finding: Recapture of Depreciation Not Returned to HCFA:

The State of Mississippi as of July 18, 1984, has calculated the recapture of depreciation for changes of ownership paid by the Medicaid program. This recapture calculation was necessary to comply with the approved State plan which incorporated the provisions of the Deficit Reduction Act of 1984 (DEFRA). DEFRA requires that for changes of ownership on or after July 18, 1984, states are required to recapture any Medicaid paid depreciation in accordance with the Medicare principles for recapture of depreciation.

Our review found that the State has calculated the recapture of depreciation properly. However, the State has not returned the Federal portion of the recaptured depreciation because of a pending lawsuit. On February 3, 1989, BQC-68, Refunding of Medicaid Overpayments, was published in the Federal Register as a final rule. These regulations were published as Title 42 CFR 433, and implemented sections 1903 (d) (2) of the Social Security Act, as amended by section 9512 of the Consolidated Omnibus Budget Reconciliation Act of 1985. These regulations stipulate that States are allowed 60 days from the date an overpayment is discovered to recover or attempt to recover that overpayment before the Federal share of the overpayment amount must be refunded to HCFA. The

guidance in these regulations complements instructions furnished in section 2853 of the State Medicaid Manual, issued in October 1986 as Transmittal No. 45.

The recapture amounts by Federal Fiscal Year are as follows:

Federal Fiscal Year	Gross Recapture Amount	FMAP	Federal Funds to be Returned
10/01/84 to 09/30/85	$ 22,094	77.68%	$ 17,163
10/01/85 to 09/30/86	1,219,642	78.42	956,443
10/01/86 to 09/30/87	672,304	78.50	527,759
10/01/87 to 11/04/87	933,623	79.65	743,631
TOTALS	$2,847,663		$2,244,996

Recommendation:

Based on this review it has been determined that an overpayment has been made in the amount of $2,244,996 in Federal funds. In accordance with the requirements of Title 42 CFR 433.312(e), this amount must be returned to the Federal Government within 60 days of the date of this letter.

State's Response:

The State had no comment on this finding.

APPENDIX N

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

(seal)

Region IV
101 Marietta Tower
Atlanta GA 30323

July 20, 1989

Refer to:
DOM/MFMB/DE

Mr. J. Clinton Smith, M.D., M.P.H.
Director
Office of the Governor
Division of Medicaid
Suite 801, Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201-1311

Dear Dr. Smith:

RE: 1989 SPECTRUM Review of ICF/MR Providers

We are writing this letter to you to clarify our position concerning our SPECTRUM report dated May 8, 1989. As we stated in our report, SPECTRUM is designed to discovery problems with the application of the State plan; i.e, determining whether the State reimbursed providers in accordance with the State plan and made the required findings, etc.

When we did our SPECTRUM review, we found that your long-term care reimbursement State plan was approved along with the assurances that the Division of Medicaid (DOM) would meet the requirements of the Deficit

Reduction Act of 1984 (DEFRA). DEFRA limited the change in reimbursement rates for property costs due to a change of ownership to the amount of change which would have been allowed for the Medicare program. In effect, States could not allow their Medicaid rates to change more than the change in rates allowed by applying the Medicare standards. Our review was based on your approved State plan and the DEFRA requirements it contains.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) became effective October 1, 1985. COBRA's provision for the Medicaid revaluation of assets for long-term care facilities was less restrictive than DEFRA. States could change their State plans to allow for upward revaluation of assets up to the COBRA limits. Since COBRA was not a mandated change, DOM did not alter its State plans. DOM retained the DEFRA limits for the revaluation of assets for changes in ownership.

However, as a result of that change, COBRA became the upper limit on reimbursement for property costs as a result of a change of ownership. Therefore, the maximum amount that would have been allowed for a change in ownership in Mississippi became COBRA on October 1, 1985. In our SPECTRUM report we erred in stating that your Agency had exceeded this upper limit allowed by Medicaid. The DEFRA limit elected by DOM was exceeded, but not the maximum upper limit, COBRA. As such, we have enclosed a revised report which has corrected that error and we apologize for any inconvenience this may have caused you.

Our review for the determination of payment rates and revaluation of assets had to be based on the approved provisions of the State plan. Therefore, the amount of unallowable cost in the finding in our previous report by which the DOM had paid in excess of the requirements of DEFRA is unchanged. Therefore, we must reiterate our position that the $174,358 FFP must be returned to the Health Care Financing Administration. The revised report, however, does reflect the different reasons to support our finding.

This finding was based on the workpapers provided to our staff by the DOM to support your assurances that the upper limit was not exceeded. Our review indicated that these workpapers were correctly prepared and document that the change in reimbursement did, in fact, exceed the amount which would have been paid under the DEFRA limit in your plan. This difference occurred as a result of the method by which the DOM staff computed the reimbursement following a change in ownership compared to the DEFRA methods utilized by the Medicare program.

If you have any questions, please call Gene Grasser, Chief, Medicaid Financial Management Branch, at (404) 331-2425 or Dick Edwards at (404) 331-2158.

Sincerely,

William R. Lyons
Associate Regional Administrator
Division of Medicaid